Health Insurance Manual

Department of Human Resource Management

June 1, 2005

APA	ADMINISTRATIVE PROCESS ACT
BES	Benefits Eligibility System
CAPP	Commonwealth's Accounting Policies and Procedures
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
DOA	Department of Accounts
DHRM	Department of Human Resource Management
DSS	Department of Social Services
ED	EmployeeDirect
Enrollment Action	Completing an enrollment form or using EmployeeDirect
FMLA	Family Medical Leave Act
GLA	General Ledger Account
HIF	Health Insurance Fund
HIM	Health Insurance Manual
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
LWOP	Leave Without Pay
ORP	Optional Retirement Plan
PCP	Primary Care Physician
PMIS	Personnel Management Information System
PPO	Preferred Provider Organization
SSA	Social Security Administration

TIAA-CREF Teachers Insurance and Annuity Association-College Retirement Equities Fund

VRS Virginia Retirement System

The Office of Health Benefits Programs, as the health plan for the Commonwealth of Virginia, is required to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. These federal regulations impose standards for safeguarding personal individually identifiable medical information, also referred to as "protected health information (PHI)." The Rule creates significant requirements and limitations in the way that PHI is handled within the Office of Health Benefits Programs and the State Agencies' Benefits Offices.

Specifically, the Privacy Rule:

- Sets boundaries on how an employee's personal health records are used or disclosed
- Establishes safeguards that the health plan and benefits offices must follow to protect PHI
- Restricts employers from using PHI in employment decisions (particularly against employees, such as in hiring/firing or promotion decisions)
- Holds violators accountable with civil and criminal penalties
- Gives employees more control over their own personal health information

HIPAA requires the health plan to provide employees and plan participants with a notice of privacy rights. The notice describes, in general terms, how the health plan will protect health information, and specifies individuals' right to:

- Obtain a copy of their PHI
- Correct errors in their PHI
- Get an accounting of how their PHI has been used and to whom it has been disclosed
- Request limits on access to their own PHI
- Complain and seek relief if they believe their own PHI has been mishandled

As required by HIPAA, this notice is to be distributed by the Agency's benefits office to all new hires and new plan participants, no later than 60 days after their enrollment into the COVA Care (self-insured) health plan.

Employee/Retiree Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Background: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the Office of State Health Benefits Programs of the Department of Human Resource Management, and the agents acting on its behalf, as the group health plan (the "Plan"), sponsored by the Commonwealth of Virginia (the "Commonwealth").

The Plan needs to create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy with respect to your health plan including Medical, Prescription Drug, Dental, Vision and Health Care Flexible Reimbursement Account (FRA) benefits. The notice tells you the ways the Plan may use and disclose health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers.

The Office of Health Benefits Programs' Pledge Regarding Health Information Privacy

The privacy policy and practices of the Plan protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Privacy Obligations of the Plan

The Plan is required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information About You

The following are the different ways the Plan may use and disclose your PHI:

For Treatment. The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The Plan may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plan may also combine health information about many Plan participants and disclose it to employees working under the Secretaries of Administration and Finance, and members of the General Assembly of Virginia in summary fashion so they can decide what coverages the Plan should provide. The Plan will remove information that identifies you from health information disclosed to these individuals so it may be used without these individuals learning who the specific participants are.

To The Commonwealth of Virginia. The Plan may disclose your PHI to designated Department of Human Resource Management personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Director of the Department of Human Resource Management and/or the Director of the Office of Contracts and Finance. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other Commonwealth employee or department and (2) will not be used by the Commonwealth for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Commonwealth of Virginia.

To a Business Associate. Certain services are provided to the Plan by third party administrators known as "business associates." For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

As Required by Law. The Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

The Plan may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

Workers' Compensation. The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws or other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The Plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funerals Directors. The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the Plan maintains about you are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

To inspect and copy health information maintained by the Plan, submit your request in writing to the Plan Administrator. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, send a detailed request in writing to the Plan Administrator. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that was: accurate and complete, not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect and copy.

Right to An Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the Plan has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations.

To request an accounting of disclosures, submit your request in writing to the Plan Administrator. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

Right to Request Restrictions. You have the right to request a restriction on the health information the Plan uses or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

To request restrictions, make your request in writing to the Plan Administrator. You must advise us: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply.

Note: *The Plan is not required to agree to your request.*

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address.

To request confidential communications, make your request in writing to the Plan Administrator. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may write to the Plan Administrator to request a written copy of this notice at any time.

Changes to this Notice

The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will provide a copy of the current notice to be posted in the Benefits Office of each Agency of the Commonwealth at all times.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Plan Administrator at the address listed below. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred.

Note: You will *not be penalized or retaliated against for filing a complaint.*

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you

revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

If you have any questions about this notice, please contact:

The Office of Health Benefits Programs
c/o The Department of Human Resource Management
101 North 14th Street, 13th Floor
Richmond, VA 23219
804/225-2131

Notice Effective Date: January 1, 2003

Definition Of "Benefits Administrator"

The Department of Human Resource Management (DHRM) administers the State and Local Health Benefits Programs in cooperation with State agencies which carry out the agency-specific aspects of program administration.

Each State agency has its own organizational structure for administering the Commonwealth of Virginia Health Benefits Program. In many agencies, responsibilities are shared by human resources and payroll/accounting staff. Further differences may occur when an agency has branch offices and duties are divided between the central office and branch offices.

We use the term "Benefits Administrator" to refer to the individual (or individuals) responsible for the duties associated with administering the Commonwealth of Virginia Health Benefits Program in State agencies.

Responsibilities Of A Benefits Administrator

If more than one person in an agency has responsibility for the State Health Benefits Program, it is important for those involved to understand who has responsibility for each part of the program. The following is a brief summary of the scope of responsibilities in administering the program.

Assist employees and retirees with enrollment and changes in plan or membership. The most important duty of the Benefits Administrator is to ensure that employees and retiring employees receive all health benefits information and that they know when they may apply for initial health benefits coverage or for changes in plan or membership. It is important that employees understand that if enrolled in an HMO they must identify a Primary Care Physician (PCP) for each covered family member to obtain maximum benefit from their health benefits plan. A Benefits Administrator should be available to counsel an employee about the types of health benefits plans available to the employee. However, the Benefits Administrator should not advise an employee concerning which plan to choose. This is a decision each employee must make based on his or her needs.

It is important to assure that all employees have the opportunity to read the *Spotlight* and all other health benefits publications distributed by DHRM. These publications contain important information about the State Health Benefits Programs.

If an employee does not apply for coverage (or changes in membership) within certain time limits, he or she may be disadvantaged by losing the opportunity to enroll in coverage or paying excess premiums. To help you provide counseling to your agency's employees, we have outlined procedures to follow when certain events occur—an employee is hired, takes a leave of absence, retires, transfers between agencies, terminates, or has a change in eligibility status, etc.

Be familiar with benefits and eligibility requirements. The Benefits Administrator is the person to whom an employee will come when he has questions about his health benefits. In order to assist the employee, it's important

that you be familiar with the general provisions of the health benefits offered under the various plans and all eligibility requirements.

Benefits Administrators are one source for employee information on eligibility and State policy. The DHRM Web site is another important source for information, plan handbooks, numbered memos, and other documents reside on this site. The address is http://www.dhrm.virginia.gov/compandbenefits.html. Additionally, the self-service system is an excellent way for employees to access information on eligibility, benefits information, and enroll or make changes in coverage. DHRM provides communications and educational material to help employees better understand their benefits and program rules.

Benefits Administrators should advise employees that each plan has an appeals process and encourage them to work through this process if there are unresolved claims issues after contact with the plans' customer service units. Additionally, the Bureau of Insurance has an Ombudsman who reviews appeals concerning medical necessity for the insured regional plan. Under the regulations of the self-funded statewide plan, there is an independent medical review appeals process, as well. An appeal may be directed to the Director of the Department of Human Resource Management (DHRM) once plan appeals are exhausted. Also, administrative appeals regarding eligibility and other non-plan issues may be made directly to the Director of DHRM. If there is an adverse determination at this level, an appellant may file an appeal under the provisions of the Administrative Process Act (APA).

***The Health Insurance Manual* (HIM)** is the administrative manual for the State Health Benefits Program, and it is maintained and updated by the DHRM Office of State and Local Health Benefits Programs. This manual should help you answer most questions which arise. If you still need more information, please refer to Section 7.3, entitled "Information And Assistance for Benefits Administrators". Additionally, numbered memos are used to communicate benefits information to agencies. Numbered memos should be maintained by the Benefits Administrator until the agency is advised to disregard the information or advised that the information has been incorporated into the Health Insurance Manual. The health benefits specialists in the DHRM are always available to assist you when an issue or question arises.

Report membership and plan information to the health benefits carriers. Most of the time, employees can make necessary enrollment changes through the self-service system which will carry the changes over to the Benefits Eligibility System (BES).

For classified employees and faculty, there must be a personnel record established for the employee on the Personnel Management Information System (PMIS), in order for the system to establish an employee "waived" record on BES. Certain categories of eligible employees including those in non-PMIS agencies and "local" employees will not have a PMIS record, but must have a BES record

established and updated accordingly. PMIS and BES are integrated systems, so certain updates to one system automatically update the other.

Any new enrollment or enrollment change not handled over the self-service system must be supported by a completed Enrollment Form. And, though most health benefits enrollments or changes are accomplished over the self-service system, Benefits Administrators will key information into BES from time to time.

The PMIS-BES User Manual provides specific information about BES and provides keying instructions for various benefits transactions. This User's Manual is maintained and updated by DHRM's Office of Information Technology.

BES serves as the enrollment and billing record for all of the State-sponsored health benefits plans.

Since carriers receive daily updates to their enrollment files, necessary changes to the BES record for enrollees of all plans should be recorded accurately and promptly. Remember, an enrollee or his dependent could be denied admission to a hospital or have claims denied if there is no record of his membership.

Monthly reconciliation through analysis of exception reports is necessary to ensure the integrity of the eligibility system and to ensure that premiums are paid for all covered persons.

Maintain confidentiality. Benefits Administrators must hold in confidence an enrollee's type of membership or plan, and especially safeguard information relating to an enrollee's medical services or claims.

Encourage employees to help contain health care costs. With today's high cost for hospital and medical care, it is important that each of us do our part to use benefits wisely. This helps to hold down the claims experience for the group and to protect the group from unnecessary costs.

Send extended coverage notification. New employees who elect coverage and their covered dependents should receive information regarding eligibility for Extended Coverage. Notification should be sent by first class mail to the address of record. Notification to the covered employee and/or spouse will be deemed notification to dependent children. Additionally, this notice must be sent when employees enroll or add a spouse to the plan. The Extended Coverage General Notice in Section 2.7 of this manual serves this purpose.

A third party administrator (the Plan) processes claims and performs medical management and customer service functions for the self-insured COVA Care plan. The premiums for the self-insured plan depends upon the amount paid out in claims in the previous year, the trend of health care cost increases, and the surplus or deficit carried forward in the Health Insurance Fund (HIF). If less is paid in claims than was expected, the savings are passed on in the form of smaller increases in premiums. However, if claims payments are greater than expected, the loss must be made up through higher premiums.

The cost of the State Health Benefits Program affects each employee. Money used to pay the State's share of premiums is part of the employee's total compensation package and no longer is available for pay increases or additional employee benefits.

The State Health Benefits Program is designed to encourage cost-efficient use of benefits. The following are ways in which employees may reduce their own out-of-pocket medical expenses and, at the same time, help to manage the monthly cost for coverage.

Ways Employees Can Help Contain Health Care Costs

Because COVA Care is the Commonwealth of Virginia's self-insured plan for active employees and non-Medicare retiree group members, each enrollee of this plan bears the liability of excessive costs and enjoys the savings of cost efficiencies. Therefore, the following remarks are geared primarily to COVA Care enrollees.

1. ***An employee must enroll only eligible dependents.*** The Commonwealth of Virginia health benefit program is available only to employees, retiree group members, and dependents who meet the State's rules for eligibility. There may be instances when you will need to assist an employee or retiree in understanding who qualifies as a dependent and why strict adherence to eligibility requirements is necessary to control costs. **Fraudulent enrollment of ineligible persons may result in the employee being removed from the program for up to 3 years.**

2. ***Except for emergencies and delivery of newborns, a COVA Care enrollee always should arrange for pre-admission review of inpatient hospital care by calling the pre-admission review unit at the Plan at least three days before entering the hospital.*** This requirement applies to all persons covered by the COVA Care plan. In the case of emergency admissions and admissions for the normal delivery of a newborn, if pre-admission review has not occurred, a call to the Plan's pre-admission review line must be made within 48 hours of the admission or the next business day. The admitting physician, the hospital, the employee, or a family member should contact the Plan's pre-admission review unit line for pre-admission

certification. If pre-admission certification is not obtained, the employee runs the risk that the admission may not be considered medically necessary, in which case the individual may become responsible for the entire cost.

The pre-admission review staff will review the information provided and follow up with the enrollee with a written confirmation and determination.

Under an HMO, emergency inpatient admissions must be reported to the patient's PCP as soon as possible, and not more than 48 hours after admission.

Refer the employee to his health benefits plan Member Handbook for further information.

3. Typically under HMO plan, any care not coordinated by the PCP will not be covered, except in the instance of an emergency. Emergency Services are defined as health care services that are provided by a Plan or non-Plan provider after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- placing the patient's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part; or
- in the case of a pregnant woman, serious jeopardy to the health of the mother and/or fetus;
- medically necessary services provided in response to a sudden and acute illness or injury which, if left untreated, would result in death or severe physical or mental impairment.

To maximize the HMO benefits, the employee should receive services from his PCP, or, when necessary, obtain a referral from his PCP for specialist services. An employee should use health care providers who "participate" with his health benefits plan to reduce his out-of-pocket medical expenses.

Employees who do not elect the out-of-network optional COVA Care benefit have no out-of-network medical benefits. A COVA Care plan member enrolled in the out-of-network option will save on out-of-pocket expenses when he receives health care services from providers who are participating in the plan's network. These providers agree to accept the plan's "allowable charge" as payment in full, leaving employees responsible for their deductible, copayment or coinsurance. On the other hand,

"non-participating" providers may charge the patient any applicable copayments plus the difference between the allowance and their charges.

COVA Care members who reside or travel outside of the plan's network may still receive in-network benefits if they utilize a Blue Card provider. Blue Card providers are members of the BC/BS plan network with which Anthem is affiliated. To locate a Blue Care provider the member should call 1-800 810-BLUE (2583).

In case of life threatening emergencies plan participants should seek immediate medical attention. The plan will pay the allowable cost of this emergency care; however, the plan member will be responsible for any cost over the allowable expense

4. ***A COVA Care enrollee should review his health care bills and /or EOB.*** The employee should always check his hospital and doctors' bills for accuracy. This can prevent erroneous payment for services which have not been received.

5. ***A COVA Care enrollee should consider a second surgical opinion***. A second surgical opinion is completely optional and is a covered service under the plan. An employee should be encouraged to take advantage of the second surgical opinion option under the self-insured plan, as it may protect him from unwarranted surgical procedures. The second surgical opinion is covered up to the allowable charge, after applicable copayments. HMO coverage for a second surgical opinion may vary by plan.

6. ***A COVA Care enrollee should avoid unnecessary tests and X-rays.*** The employee should request that previous lab tests, X-rays, and other medical tests be forwarded to a doctor who is consulting on his care if the doctor does not have his medical records. This can avoid costly duplication of tests and enhance the quality of the patient's care. Also, pre-admission testing should be done in an outpatient setting whenever possible.

7. ***A COVA Care enrollee should take an interest in discharge planning.*** As soon as possible after admission, an employee should discuss with his or her doctor when it will be feasible to return home. If the employee is not actually ill, but still needs rest in bed, it is safer, more comfortable, and less expensive in his or her home.

8. ***An employee may be able to utilize home health benefits.*** For certain patients, home health benefits may allow a patient to be discharged from the hospital early or to stay out of the hospital altogether.

9. ***A COVA Care enrollee should maximize the benefits of the Outpatient Prescription Drug Program.*** Members of COVA Care, Advantage 65, or the Medicare Complementary (Option I) plan are also members of the Commonwealth's Outpatient Prescription Drug Program. The mail order component of the Outpatient Prescription Drug Program is the most cost-efficient and convenient way for an employee to have prescriptions filled without leaving home. The employee should emphasize to his physician that the State Program provides the greatest benefit when generic equivalent drugs are prescribed.

A member of an HMO plan obtains his prescription drug benefits through the HMO. Under the Medicare Supplemental (Option II) plan, prescription drug benefits are covered under the Major Medical portion of the benefit.

10. ***A COVA Care enrollee should understand the savings associated with Coordination of Benefits.*** The employee or retiree who is enrolled in a State health benefits plan should provide the plan with information about any other health insurance policy in which he or his dependents may be enrolled. With Coordination of Benefits (COB), the State health benefits plans work with other health care carriers to ensure that the enrollee receives all available benefits without making duplicate payments for the same services. This cost control feature is included in all State health benefits plans, and it helps to hold down the overall cost of benefits.

At a specified time during the year, the COB surveys will be sent to each COVA Care enrollee with Employee Plus One or Family membership. The health benefits plan customer service representatives can explain how COB would work in a given employee's case. Persons who do not respond to the Plan should be counseled that claims will be pended until the information is received.

Plan Options

A State employee who is eligible for health benefits may choose to enroll in the statewide, self-insured COVA Care plan along with several coverage options.

They may also enroll in a Health Maintenance Organization plan, if they live or work in the plan's service area. The following plans are available:

- ***COVA Care Basic***, an Exclusive Provider Organization (EPO) plan, is available to all non-Medicare participants. Coverage for out-of-network services applies only to emergency care. An emergency is defined as medically necessary services provided in response to a sudden and acute illness or injury which, if left untreated, would result in death or severe physical or mental impairment. In addition to participating providers in Virginia the plan provides coverage to providers who participate in Anthem's Blue Card PPO network.

  - ***COVA Care Plus Out of Network*** provides coverage for employees and eligible retirees wherever they live or travel. An out-of-network benefit is limited to 75% of the plans allowable expense.

  - ***COVA Care Plus Expanded Dental -*** This is the COVA Care basic plan with expanded dental coverage.

  - ***COVA Care Plus Vision, Hearing, and Expanded Dental -*** This is the COVA Care basic plan with vision, hearing, and expanded dental.

  - ***COVA Care Plus Out of Network and Expanded Dental.*** This provides an *out of network option (75%* of the allowable charge) to the basic plan along with an expanded dental benefit.

  - ***COVA Care Plus Out of Network and Vision Hearing and Expanded Dental*** This allows the employee to choose all of the above options in one plan.

Health Maintenance Organizations (HMOs) Kaiser Permanente is available in northern Virginia**.** To be eligible for membership in the Kaiser plan, the employee must live or work within Kaiser's service area. Eligible retirees must live in the service area. Out-of-area services may not be covered except in the case of an emergency.

See Section 5.7 for more information about plans available to Medicare-eligible retiree group members.

Outpatient Prescription Drug Program for the COVA Care Plan, Advantage 65 Plan, and the Retiree Option I Plan

The Outpatient Prescription Drug Program is included in the COVA Care, Advantage 65, and Option I plans. This is a mandatory generic outpatient prescription drug program. This means if a generic equivalent is available, but a brand name is filled, the employee will be responsible for the difference between the reimbursement for the generic drug and the cost of the brand name drug plus the co-payment.

Certain drugs will require prior authorization. The Plan will make a decision on coverage of the drug within 48 hours of receipt of necessary physician documentation. The member handbooks provide detailed information on prior authorizations.

A covered person should present his prescription drug plan identification card to the pharmacist when filling prescriptions. Dependents' eligibility will be verified by birth date. Eligibility is confirmed by the pharmacy through a direct line with the Plan.

Maintenance prescription drugs prescribed for the treatment of long-term or chronic illnesses may be filled through the mail service program. Mail service is a cost efficient and safe mechanism for obtaining medication in up to a 90-day supply.

The HMO plan and the Medicare Supplemental Plan (Option II) offer their own prescription drug programs. Benefits are outlined in the plans' member handbooks.

1. Administration. Limited retroactivity is provided to protect an employee in the instance of agency error in the administration of the employee's health benefits. All requests for retroactivity beyond the agency's 59-day capability must be submitted in writing by an agency Benefits Administrator to DHRM. The contractual limitation for the statewide self-funded plan is 12 months. The HMO limits retroactive changes to a period of 60 days from their receipt of a copy of DHRM's authorization to the agency. Agencies should be aware that an employee may wish to seek remedy from the agency in the case of agency error if the period of retroactivity does not afford the employee full remedy.

2. Agency Premium Refunds. Premium refunds to agencies that result from agency error will be based upon a correction of the corresponding BES record. Agencies are limited to 59 days when making corrections to BES. If the BES record does not correspond to the refund request, DOA will not issue a refund. In most cases, DHRM will not authorize retroactive refunds beyond the 59-day limited retroactivity.

Eligible employees are State employees who are:

- Full-time salaried classified employees
- Part-time salaried classified employees
- Full-time Faculty
- Part-time Faculty

Generally, a State employee is one who is salaried and receives a State paycheck no more often than biweekly and who is not paid on an hourly basis. A full-time salaried employee is one who is scheduled to work at least 32 hours per week or carries a faculty teaching load considered to be full time at his or her institution. In order to be eligible for this plan, part-time employees must work at least 20 hours per week on a regularly scheduled basis.

Certain employees in auxiliary enterprises (such as food services, bookstores, laundry services, etc.), at Virginia Military Institute and the College of William and Mary as well as other state institutions of higher learning are also considered State employees even though they do not receive a salaried state paycheck. The Athletic Department of Virginia Polytechnic Institute and State University is an example of a local auxiliary whose members are eligible for the program.

A classified position includes three (3) categories:

1. Employees who are fully covered by the Virginia Personnel Act;
2. Employees excluded from the Virginia Personnel Act by Article 2.1-116 (16) of the Code of Virginia; and
3. Employees on a restricted appointment.

A restricted appointment is a classified appointment to a position that is funded at least 10% from gifts, grants, donations, or other sources that are not identifiable as continuing in nature. An employee on a restricted appointment must receive a State paycheck in order to be eligible.

Eligibility is defined in paragraph D. of Section 2.2-2818, Section 51.1-124.3, and Section 51.1-201 of the Code of Virginia. The following sections of the Code of Virginia define employees eligible for the Health Benefits Program:

§ 2.2-2818 Health and related insurance for State employees.

D. For the purposes of this section, the term "State employee" means state employee as defined in §51.1-124.3 of the Code of Virginia, employee as defined in §51.1-201 of the Code of Virginia, the Governor, Lieutenant Governor and Attorney General, judge as defined in §51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth.

§ 51.1-124.3

"State employee" means any person who is regularly employed [*] on a salaried basis, whose tenure is not restricted as to temporary or provisional appointment, in the service of, and whose compensation is payable, no more often than biweekly, in whole or in part, by the Commonwealth or any department, institution, or agency thereof: "State employee" includes the Governor, Lieutenant Governor, Attorney General, and members of the General Assembly but does not include:

(i) any local officer,
(ii) any employee of a political subdivision of the Commonwealth,
(iii) any member of the State Police Officer's Retirement System, or
(iv) any member of the Judicial Retirement System.

§ 51.1-201 Definitions

"Employee" means a state police officer.

[*] .

Except as noted here, coverage elections including those made by new employees are made on a prospective basis, that is, effective the first of the month coinciding with or following the receipt of the election form. However, if the employee's start date is the first business day of the month and, if an election action is taken that day, coverage for the employee will commence on the first day of that month. New employees must enroll for coverage within 31 days of the beginning of employment. Coverage elections made for newborns, adoption or placement for adoptions are effective the date the child is born, adopted or placed for adoption, so long as the employee makes the coverage election within 31 days of the event. The practical effect of adding a child or other family members as of the date of adoption or pre-adoptive placement is that, if membership must be broadened, the change to Anthem's system must occur retroactive to the first of the month of the event. Thus, the Benefits Administrator must notify Anthem that claims may be processed for services occurring on or after the event date (birth/adoption or placement for adoption).

Coverage terminations are effective the end of the month following receipt of an election notice, except for terminations which are required by the plan. Coverage terminations required by the plan are effective the end of the month that the event takes place. Examples of coverage terminations required by the plan are such things as a divorce, termination of employment or a dependent child losing coverage.

An employee must experience a qualifying mid-year event, or wait until Open Enrollment before he can enroll himself or any eligible dependents in the plan. Enrollments due to a qualifying midyear event must be consistent and on account of the event.

Active group coverage ends at the end of the month in which an employee terminates work or otherwise loses group eligibility. Extended Coverage must be offered to all covered persons in the case of a Qualifying Event which causes the employee to lose eligibility.

When an employee or dependent loses coverage, he must receive a Certificate of Coverage. A Certificate of Coverage provides evidence of prior health coverage. Employees may need to furnish this certificate if they become eligible under a group health plan that excludes coverage for certain medical conditions that existed before enrollment. This certificate, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is available to all employees leaving the State Health Benefits Program. See Section 2.8, Certificates of Coverage, for additional information.

The State plan contracts are effective July 1 through June 30, and premiums are subject to change beginning July 1st. Premium payments are collected from employees during the month of current coverage. For example, an employee who is paid monthly has September's payment deducted from the September paycheck. An employee who is paid twice a month has half of September's payment deducted from each September paycheck.*

Coverage is on a monthly basis only. If an employee works only a portion of a month, the full month's premium still is due.

The plan requires that all employee contributions made to the plan, through payroll deduction, are on a pre-tax basis.

* See Section 6.1 for information specific to faculty coverage and premium payments.

Single Membership Single membership covers only the employee or retiree/survivor/LTD participant.

Employee Plus One Membership If an employee elects Employee Plus One membership, the employee and either the spouse or one other eligible dependent may be covered. The eligibility rules for family members are described under Family membership.

Family Membership If an employee elects Family membership, the following family members may be covered:

- The employee's legally married spouse.
- The employee's unmarried biological or legally adopted children, or children placed in the home under a pre-adoptive agreement which is approved by the Department of Human Resource Management (DHRM).
- Unmarried stepchildren living full time with the employee in a parent-child relationship who are eligible to be claimed on the employee's federal tax return. A stepchild will be considered living full time with our employee, even if the stepchild periodically visits the other natural parent on the weekends or during summer vacation, so long as the employee's home remains the legal residence.

  Example: An employee is married to an individual who is responsible for providing health benefits for his or her children who live part-time or full-time with a previous spouse. The employee may not cover these children, as they are not the biological or legally adopted children of the employee, nor do they live full time with the employee as dependents. Even if a court has ordered the employee's spouse to provide health insurance for the children, the spouse's court order to provide health benefits does not make them eligible for coverage in the State Program.

- Adult disabled children, if the qualifying disability was diagnosed and caused the incapacitation prior to the loss of eligibility for coverage due to age. Enrollment should be applied for and approved by the plan administrator prior to the loss of coverage for employees enrolled in a regional plan. For the statewide plans (COVA Care) application must be made within 31 days of the loss of coverage. A child who recovers is no longer eligible to participate in the plan, and should the child become disabled again will not be allowed to re-enroll in the plan.

"Other children," on an exception basis. The child may be added only if a court orders the eligible employee or employee's spouse to assume permanent custody of the child. A copy of the order of permanent custody must be maintained in the agency's files. If the court order does not indicate permanent custody, assure that there is no indication that custody is temporary in nature. Temporary custody does not meet this criterion.

Normally, the employee or employee's spouse must have sole custody for the "other child" to be eligible for coverage. There is one exception, if the employee or spouse shares custody with the minor child who is the parent of the "other child" living in the home of the employee, then the other child may be covered. The other child, the parent of the other child, and the spouse who has custody must be living in the same household as the employee.

"Other Children" who become eligible by reason of custody may be added within 31 days of the employee's obtaining permanent custody or during the Open Enrollment period. If there is an existing family membership when custody is obtained, the child may be added immediately. Coverage will be effective prospectively based on the receipt of the enrollment action. Other children may be covered to age 23 so long as custody was granted prior to age 18, and they meet the other eligibility criteria.

Minor children who are adopted enjoy the same benefits as biological children. Biological or adopted children who are otherwise eligible for coverage may be covered by the State employee whether or not they live with the employee.

There are certain categories of persons who may not be covered under an employee's Employee Plus One, or Family membership. These include: siblings, even if dependents, grandchildren, nieces, nephews, and most other children, except in the rare instances where the criteria for "other children" are satisfied. Parents, grandparents, aunts, and uncles are not eligible for coverage regardless of dependency status.

Dependent Child Eligibility

Unmarried biological and adopted children who are otherwise eligible for coverage may be covered under the employee's Employee Plus One or Family membership if the child lives at home and is eligible to be claimed on the parent's federal income tax return. In the case of biological or adopted children, living at home may mean living with the other biological or adoptive parent. Biological or adopted children who are living away from home while attending college or boarding school may be covered. Dependent children who lose eligibility must be removed from coverage at the end of the month in which eligibility is lost.

Coverage for a dependent child stops at the end of the month in which the child marries.

Under the State employee's health benefit plans, an eligible child may be covered to the end of the calendar year in which he or she turns age 23, regardless of student status, if the otherwise eligible child lives at home and is eligible to be claimed on the parent's federal income tax return. Children may be covered regardless of age if incapable of self-support because of severe physical or mental handicap which was diagnosed while coverage was in force. This handicap must have existed prior to the termination of coverage and the plan administrator must approve continued coverage.

NOTE: An employee's failure to remove ineligible persons from his or her health benefits membership can result in the retraction of claims and other penalties as delineated in Section 210 of the State Health Benefits Program Regulations. Additionally, the employee will be unable to reduce health benefits membership except within 31 days of the dependent's loss of eligibility or during open enrollment.

2.5 Medicare Benefits for Active Employees

Active employees and their dependents who are eligible for Medicare may choose to remain in a State plan and the State will be their primary insurance. However, eligibility for Medicare is a qualifying event that would allow a participant to make a membership or plan change consistent with that event. This means that an employee who becomes eligible for Medicare may terminate his/her State coverage or, if a covered dependent becomes eligible for Medicare, reduce membership, as appropriate, if they do so within 31 days of the Medicare eligibility. Employees who terminate their own coverage due to eligibility for Medicare will also terminate coverage for any covered dependents.

Active participants and their dependents who are eligible for Medicare due to end stage renal disease (ESRD) may also either remain in the active health benefits group or discontinue coverage upon Medicare eligibility as explained above. However, if the State Health Plan coverage is maintained, it will pay primary to Medicare during the 30-month coordination period (see below). After the 30-month period, Medicare will become the primary payer, and the State plan will coordinate with Medicare and pay secondary on claims. If Medicare Part B coverage is waived during the coordination period, the participant should be sure to contact the Social Security Administration to ensure that Medicare Part B is in place as soon as the coordination period ends.

Anthem, as claims administrator for the self-funded plans, must monitor active plan participants whose claims should be paid secondary to Medicare per the above guidelines. As a precaution, Benefits Administrators who are made aware of the coordination period should contact Anthem to ensure that they are also aware of this information.

When the 30-Month Period Begins (ESRD)

The 30-month period begins:

1. The first month of eligibility for Medicare because of kidney failure (usually the fourth month of dialysis), or
2. The first month of a kidney transplant if the transplant occurs during the three-month waiting period, or
3. The first month of dialysis if a self-dialysis training course is taken during the initial three-month waiting period.

The Department of Accounts (DOA) has a procedure for the active employee or covered dependent to be reimbursed for Medicare Part B when Medicare becomes primary payor after the referenced 30-month period. DOA can provide instructions regarding reimbursement for Medicare Part B.

Retirees must apply for coverage within 31 days of termination of employment for retirement. *(Some exceptions may apply to enrollment time frames for certain involuntarily terminated State employees and for retroactive disability retirements—see Section 5.7 for more detail.)*

Retirees and their dependents who are not eligible for Medicare may choose from the same plans as active employees, but they must pay the full premium. Retiree group members who are not eligible for Medicare may make plan/membership changes based on consistent qualifying midyear events or at open enrollment. However, if coverage is canceled at any time, there can be no re-enrollment in the program.

Medicare and non-Medicare Retirees with 15 years or more of Virginia Retirement System service are eligible for a Health Insurance Credit through the Virginia Retirement System (VRS). This credit is paid directly to the retiree who has either state retiree health plan coverage or alternative coverage to assist in the cost of any health benefits. Contact VRS for additional information on the health insurance credit or to obtain a Retiree Health Insurance Credit Form.

Retirees and their dependents over age 65 (or who otherwise are eligible for Medicare) must enroll in a Medicare-coordinating plan if they wish to continue coverage in the State Retiree Health Benefits Program. They may elect Advantage 65, the state Medicare supplement plan, or Advantage 65 with Dental/Vision. Dental/Vision coverage may be added to Advantage 65 one time on a prospective basis. However, once Dental/Vision has been added and canceled, it may not be added again. Some Medicare-eligible retiree group members are enrolled in the Option I and Option II Plans, but these plans are only available to current members and are not available to new retirees or retirees newly eligible for Medicare.

The following rules apply to plan/membership changes for Medicare retirees:

- Membership changes can be made within 31 days of the occurrence of a consistent qualifying midyear event. (Medicare retirees do not have an open enrollment period.)

- Medicare retirees may cancel coverage prospectively at any time, but once coverage is canceled, they may not re-enroll in the future.

- Option I and Option II participants may switch coverage between those two plans on a prospective basis.

- Medicare retirees enrolled in Option I or Option II may elect Advantage 65 prospectively at any time as long as continuous coverage is maintained.

However, once they have left Option I and Option II, they may not re-enroll at any time.

- Like Advantage 65 participants, Option II participants may add Dental/Vision to their coverage one time on a prospective basis. However, once Dental/Vision has been added and canceled, it may not be added again.

Retiree Fact Sheets

Retiree Fact Sheets are available on the DHRM Web site and contain subject-specific information for retiree group participants.

Other Resources

See Sections 5.7 and 5.8 for additional information on ***Coverage at Retirement*** and ***Processing Retirement Benefits***.

Extended Coverage is a term which DHRM uses to describe continued health plan coverage required of government employers under the provisions of the Public Health Service Act. These are the same provisions which apply to private employers under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Under certain circumstances, a participant who would ordinarily lose coverage because of specific Qualifying Events is a Qualified Beneficiary who may elect to continue coverage under the State Health Benefits Program for a period of up to 36 months, at his or her own expense. As with Extended Coverage for health benefits, employees who are enrolled in a Medical Reimbursement Account may choose to extend participation in the program if the maximum benefit available in the account on the event date is more than the maximum amount that the plan could require as payment for the remainder of the plan year. Extended Coverage of a Medical Reimbursement Account may only continue until the end of the plan year for which the original election was made. The Flexible Benefits Administrative Manual provides additional information regarding Extended Coverage for Medical Reimbursement Accounts.

All persons who cease to be covered under the State Health Benefits Program for any reason must be issued a Certificate of Creditable Health Coverage, as required by the Health Insurance Portability and Accountability Act (HIPAA). A form can be found at the end of Section 2.8 and on the DHRM Web site.

There is no agency contribution toward Extended Coverage (unless it is running concurrently with another benefit). A fee of 2% is added to the total monthly premium for health benefits (except when there is a fee of 50% added for the last 11 months of Extended Coverage when a disability extension applies).

In the case of the following Qualifying Events, coverage may be continued up to 36 months at the individual's own expense.

- Death of the employee under whose membership the affected person was enrolled as a spouse or as a dependent child.
- Divorce, when the affected person was enrolled as a spouse. If coverage is reduced or eliminated in anticipation of an event (for example, an employee eliminating coverage for a spouse in anticipation of a divorce), the affected person still is eligible for Extended Coverage. Upon receiving timely notice of the Qualifying Event, offer Extended Coverage in conjunction with the date of divorce, but not for any period before coverage would have been lost due to the Qualifying Event.
- Loss of dependent child status by a person enrolled in health benefits through the State Program.
- A special rule applies to employees who terminate employment or reduce hours within an 18-month period after the employee becomes

entitled to Medicare. In this case, if a spouse or dependent elects Extended Coverage, the period of coverage would be 36 months from the end of the month in which the employee's Medicare eligibility occurred.

In addition, an employee and his/her dependents who are covered immediately prior to the following events may elect to extend coverage under the program for a period of up to 18 months at his/her own expense.

- Voluntary or involuntary (except for gross misconduct) termination of employment. (Since COBRA does not provide an official definition of "gross misconduct", denial of Extended Coverage benefits for this reason should be reviewed by the Office of the Attorney General.)
- Reduction in work hours that results in a loss of coverage, loss of employer contribution or a change in the terms and conditions of coverage, including going on leave without pay, long-term disability, or to any part-time employment status, is a Qualifying Event. Please note, however, that when an employee goes on an approved family medical leave (FMLA), the Qualifying Event does not occur until the end of the 12 week period or at the point when the employee gives notice of intent not to return from the FMLA. Additionally, employees may remain in the active group for up to 12 months, depending on the reason for LWOP (see chart in Section 5.3), and this period of time will run concurrently with eligibility for Extended Coverage. Election of coverage as an LTD participant, part-time employee or LWOP participant does not relieve the requirement to offer Extended Coverage, eligibility for which runs concurrently with the other programs. Failure to do so may result in liability to the program.

Example:

- An employee goes on sick LWOP June 14.
- The agency offers Extended Coverage as soon as possible, but no later than 14 days after June 30 (the end of the month in which the last day of unreduced hours occurs) and the clock starts July 1, though the employee may remain in active coverage for the period allowed.
- At the end of the LWOP active coverage, the employee may have Extended Coverage for a period of 18 months minus the period of active coverage while on LWOP. The employee will have 60 days from the loss of "active" coverage in which to elect the remaining months of Extended Coverage. In this example, there would be six months of Extended Coverage remaining since the first 12 months

ran concurrently with the 12 months of active coverage while on LWOP.

A Qualified Beneficiary may have more than one Qualifying Event, but the period of coverage may not exceed 36 months. The 36-month period is measured from the date of the first Qualifying Event. For example, a spouse has Extended Coverage for up to 18 months because the employee terminated employment. The marriage ends in divorce nine months into the 18-month period. The spouse would be eligible for 36 months of coverage less the 9 months already received, that is, for another 27 months of coverage if notification of the second event is timely.

Special rule for disabled individuals: If a Qualified Beneficiary is determined by the Social Security Administration to be disabled at some time during the first 60 days of Extended Coverage (even if the original determination was prior to the qualifying event) and the disability lasts at least until the end of the initial 18-month period of continuation coverage, an 11-month extension of coverage may be available to all qualified beneficiaries in that family group, resulting in a total of up to 29 months of continuation coverage. Notification of the disability determination must be given to the Office of Health Benefits Extended Coverage Administrator within 60 days of either (1) the date of the disability determination, (2) the date of the qualifying event, (3) the date on which the qualified beneficiary would lose coverage under the plan due to the event, or (4) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice (e.g., through the general or election notice) AND within the first 18 months of Extended Coverage.. After the initial 18 months, the administrative fee added to the monthly premium increases from 2% of total premium to 50%. Timely notification should include a copy of the SSA disability certification sent to the Office of Health Benefits Extended Coverage Administrator. If the Qualified Beneficiary ceases to be disabled after the 18-month period, but before the end of the 29 months, Extended Coverage will end for all qualified beneficiaries and covered family members the first of the month that is more than 30 days after the loss of disability determination. The Election Notice includes specific information as to the required format and timing of both notifications of disability and notifications of loss of disability.

Eligibility for Extended Coverage ends at the earliest of any of the following:

- Failure to make a premium payment when due.
- Becoming covered under any other group health plan which does not contain any exclusion or limitation regarding a pre-existing condition of such Qualified Beneficiary. This provision does not apply if the other coverage was in place prior to the Extended Coverage election.

- Entitlement to Medicare if entitlement occurs after the date of the Extended Coverage election.
- Expiration of the 18-, 29-, or 36-month coverage period.
- Ceasing to be disabled during the 11-month disability extension.

The appropriate carrier or the Office of Health Benefits Extended Coverage Administrator is required to notify any qualified beneficiary whose Extended Coverage is terminated prior to the full 18, 29 or 36-month coverage duration, including the reason for early termination.

Affected persons are allowed a 60-day election period in which to enroll in Extended Coverage. The election starts with the later of:

- the date the Election Notice was mailed, or
- the date coverage under the State Program would end due to the qualifying event.

Premiums for Extended Coverage are 102% of the total premium amount (no agency contribution), except in the case of the 11-month disability extension, as addressed above. A Qualified Beneficiary has 45 days from the date of the election to make the initial payment. After the first payment, premiums are due the first of the coverage month, but with a 30-day grace period.

If eligibility for Extended Coverage ends because of the expiration of the 18-, 29-, or 36-month term, the affected person may convert to non-group coverage, just like any other member of the State Group, by applying for coverage within 31 days of the loss of Extended Coverage. Furthermore, the employee may have certain additional rights which may be exercised when securing individual coverage. Employees should be advised that insurers that offer individual health plans in the Commonwealth must recognize creditable coverage so long as the employee has at least 18 months of creditable coverage without a 63-day break and received their most recent health coverage under an employer-related group health plan.

Qualifying Events are not the same as mid-year events, so a Qualified Beneficiary may not add new members upon enrollment. However, each Qualified Beneficiary is entitled to an independent election with respect to whether or not to enroll in Extended Coverage. A parent or legal guardian may elect on behalf of a minor child, and a Qualified Beneficiary who is the spouse of an employee may make a binding election to provide Extended Coverage for other covered dependents. Persons enrolled in Extended Coverage may change their type of membership if they experience a consistent qualifying mid-year event, as defined in this manual. Furthermore, individuals enrolled in Extended Coverage may

utilize the annual Open Enrollment period (does not apply to Medicare-eligible retiree group participants).

In most instances, a group (family) of Qualified Beneficiaries is closed as of the day before the Qualifying Event. A Qualified Beneficiary who fails to elect coverage ceases to be a Qualified Beneficiary at the end of the election period, although a declination of coverage may be withdrawn before the end of the election period.

Children born to or placed for adoption with a covered employee during the period of Extended Coverage are considered Qualified Beneficiaries and may be covered based on the applicable Extended Coverage period defined by the original qualifying event.

Administration Of Extended Coverage

General Notice - Benefits Administrators must provide all new state health plan members with an Extended Coverage General Notice within 90 days of their coverage effective date. Notices should be sent by first class mail and addressed to the employee/retiree group member and the covered spouse or family, as appropriate. In the case of dual or family coverage, providing the General Notice only to the employee does not fulfill this notice requirement. Benefits Administrators who have knowledge that covered spouses are living separately from the covered employee should make every effort to deliver the notice to the correct address. In all cases, delivery of notice should be documented in a consistent manner for all beneficiaries. The addition of dependents due to qualifying mid-year events or at open enrollment requires the generation of an appropriately addressed General Notice within 90 days of the coverage start date. Failure to provide a General Notice relieves the affected beneficiary of restrictions and requirements addressed in the notice (e.g., time limitation for qualifying event notices, etc.) and results in potential liability to the program. A sample general notice is included in this manual and is available at the DHRM web site.

Agencies are responsible for:

- delivering timely, accurate notices,
- consistently documenting mail delivery of notices,
- counseling potential Qualified Beneficiaries,
- determining the months of coverage available,
- certifying eligibility,
- seeing that Enrollment and Election Forms are completed correctly; and,
- entering the initial enrollment information into BES.

The appropriate agency Benefits Administrator is responsible for initial entry of Extended Coverage eligibility into the Benefits Eligibility System

(BES). After initial enrollment, Extended Coverage is administered by the Office of Health Benefits' Extended Coverage Administrator.

All dates are unalterable. Sixty days, for example, means exactly 60 calendar days, except that the last day of the period must end on a business day. The day on which an event occurs (for example, giving notice) is not counted in the period. All dates are counted from the date when the notice, Enrollment Form, etc., are sent, not the date received.

Election Notices - Qualifying event Election Notices should be complete (including rate information), properly addressed (e.g., to employee and spouse/family as applicable), documented, and delivered by U.S. Postal Service using first class mail. Just like General Notices, a single Election Notice may be sent to qualified beneficiaries living at the same address, but you must make every effort to deliver separate notices to those living apart, and be sure to document your efforts to properly deliver.

Employees who are enrolled in a Medical Reimbursement Account must be offered the opportunity to extend participation in that program.

Please see the *Flexible Benefits Administrators Manual* for more information on extending participation in a Medical Reimbursement Account.

It is the responsibility of the agency Benefits Administrator to mail an Election Notice to qualified beneficiaries as a result of an employee's death, termination of employment (including retirement) or reduction of hours (including employees going to LTD or to classified part-time employment when the agency contribution is lost, or to LWOP) within 14 days of the date coverage would have been lost due to the qualifying event, but you are encouraged to send the notice as soon as possible. Failure to provide an appropriate Election Notice results in potential liability to the program.

It is the responsibility of the employee, qualified beneficiary or his/her representative to provide written notice of a qualifying event that is divorce or loss of dependent child status (DHRM will track superannuation and remind Benefits Administrators annually of their responsibility). Notice must be given within 60 days of the date coverage would be lost due to the qualifying event. The format of the notification is documented in the General Notice. Failure to provide notice within this 60-day period results in the loss of Extended Coverage rights. The Benefits Administrator must provide the Election Notice within 14 days of notification, but it should be sent immediately upon notification if

possible. As with the General Notice, one properly addressed Election Notice may be mailed to affected Qualified Beneficiaries living at the same address. However, if you have knowledge that the Qualified Beneficiaries live separately, it is your responsibility to make every effort to mail the Election Notice to the correct address. It may sometimes be difficult to secure the cooperation of the employee in obtaining addresses for delivering notices to some affected persons. In these cases, send the notice to the address of record and document your efforts to obtain accurate information.

It is also the qualified beneficiary's (or a representative's) responsibility to provide written notice of a second qualifying event that would extend the coverage period from 18 to 36 months. This notice must be sent within 60 days of the date coverage would have been lost due to the second qualifying event, and failure to provide timely, written notice will result in loss of the right to an extension. The format of the notice is provided in the General Notice. Also, written notice, along with documentation from the Social Security Administration, must be provided by the qualified beneficiary (or a representative) within the time frame explained previously in this section and as provided in the General Notice in order to qualify for the 11-month disability extension.

If a Benefits Administrator receives notice of a qualifying event or a request for Extended Coverage that does not meet the requirements of the Public Health Service Act (e.g., failure to provide notification of a divorce within 60-day notification period defined above, termination of coverage at open enrollment), it is the responsibility of the Benefits Administrator to provide a written response to the requestor, explaining the reason that Extended Coverage is being denied. This response must be sent within 14 days of the notification or request.

Once the agency has provided an Election Notice, the Qualified Beneficiary/ies have 60 days from the date of notice (or the date coverage would be lost, if later) to elect Extended Coverage for a period which begins the first of the month after the month in which the qualifying event occurs.

The Benefits Administrator is responsible for entering all initial Extended Coverage enrollment information in the Benefits Eligibility System (BES), and this information will be sent electronically to the appropriate carrier. Retain the original Extended Coverage Enrollment form at the agency.

To update BES:

- Use PSB109, SSN and transmit next to the appropriate Extended Coverage (COBRA) group,

- Transmit next to the reason for the Extended Coverage (COBRA) enrollment,
- Verify the enrollment information displayed on the PSB301, make changes if necessary, and transmit.
- Failure to transmit on the PSB301 will result in an unsuccessful transfer to Extended Coverage (COBRA).

The Office of Health Benefits (OHB) will be responsible for processing subsequent changes for existing Extended Coverage (COBRA) participants. The participant may request changes either by using EmployeeDirect on the Web at http://edirect.virginia.gov or by submitting a completed Extended Coverage enrollment form to OHB's Extended Coverage Administrator.

The effective date of coverage should generally be the day after the date that the member was dropped from the Active Group unless there is a period where Extended Coverage runs concurrently with alternative coverage in the active group (e.g., LWOP, LTD). A person may not be transferred to Extended Coverage until his or her membership in the Active Group has been terminated on the Benefits Eligibility System.

GENERAL NOTICE OF EXTENDED COVERAGE RIGHTS
Date

Address this notice as appropriate to:

- **The employee, or**
- **The employee and spouse, or**
- **The newly covered spouse.**

at the mailing address(es) of record

Introduction

You are receiving this notice because you have recently become covered under the Commonwealth of Virginia Health Benefits Program (the Plan), including the health benefits plan and, if you elected to enroll, the medical expense flexible reimbursement account. This notice contains important information about your right to temporarily extend your coverage under the Plan. **This notice generally explains Extended Coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to Extended Coverage was created for private employers by federal law through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and these rights are reflected in the continuation coverage provisions of the Public Health Service Act which covers employees of state and local governments. Extended Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the plan and under the law, you should contact your designated Benefits Administrator. For active employees, this would be the individual designated by your employing agency to administer eligibility for the Plan, including initial Extended Coverage enrollment. For retirees, survivors or long-term disability participants (retiree group participants), this would generally be the Virginia Retirement System. However, local retirees/survivors or optional retirement plan retirees/survivors should contact their pre-retirement agency's Benefits Administrator. Contact the Human Resources Department of the appropriate entity (as previously noted) if you need assistance in determining the name and mailing address of your specific Benefits Administrator. Resources for additional information are provided on page 4.

What is Extended Coverage?

Extended Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, Extended Coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent

children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. These rights are also available to children covered through a Qualified Medical Child Support Order (QMCSO). Under the Plan, qualified beneficiaries who elect Extended Coverage must pay the full cost for Extended Coverage. Time limitations for making Extended Coverage premium payments will be included in the Election Notice provided at the time of the qualifying event.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:

- Your hours of employment are reduced. This would include periods of leave without pay (even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage) and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee or retiree group participant, you will become a qualified beneficiary if you lose your coverage under the plan because of any one of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced (including periods of leave without pay, even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage, and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage);
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of any one of the following qualifying events:

- The parent/employee/retiree dies;
- The parent's/employee's hours of employment are reduced (including periods of leave without pay, even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage, and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage);
- The parent/employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced, resulting in loss of dependent eligibility;
- The child stops being eligible for coverage as a dependent child under the plan.

Coverage that is terminated in anticipation of a qualifying event (e.g., divorce) is disregarded when determining whether the event results in a loss of coverage. If termination occurs under this condition but notification of the qualifying event is received from the employee, qualified beneficiary or a representative within 60 days of the date coverage would have been lost due to the qualifying event, Extended Coverage must be made available and effective on the date coverage would have been lost due to the event, but not before.

When is Extended Coverage Available?

Your Benefits Administrator will automatically offer Extended Coverage to qualified beneficiaries upon the occurrence of the following qualifying events:

- Termination of employment;
- Reduction in hours of employment resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage, including leaves without pay;
- Death of the employee.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse or a dependent child's loss of eligibility for coverage as a dependent child), you or your representative must notify your Benefits Administrator within 60 days of the qualifying event (or within 60 days of the date coverage would be lost due to the qualifying event) by submitting written notification to include the following information:

- The type of qualifying event (e.g., divorce, loss of dependent child's eligibility--including reason for the loss of eligibility);
- The name of the affected qualified beneficiary (e.g., spouse's and/or dependent child's name/s);
- The date of the qualifying event;
- Documentation to support the occurrence of the qualifying event (e.g., final divorce decree, dependent child's marriage certificate);
- The written signature of the notifying party;
- If the address of record is incorrect, an address for mailing the Election Notice.

Failure to provide timely notice of these qualifying events will result in loss of eligibility for continuation coverage. One notice will cover all affected qualified beneficiaries. Notice will be considered furnished when mailed or, in the case of hand delivery, the date it is received by your Benefits Administrator.

How is Extended Coverage Provided?

Once the designated Commonwealth of Virginia Benefits Administrator becomes aware or is notified that the qualifying event has occurred, Extended Coverage will be offered

to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect Extended Coverage. Covered employees may elect Extended Coverage on behalf of an eligible spouse, and parents may elect Extended Coverage on behalf of their eligible children.

Extended Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee/retiree, your divorce, or a dependent child's loss of eligibility as a dependent child, Extended Coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, Extended Coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before his coverage ends due to termination of employment, Extended Coverage for his covered spouse and/or children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date that coverage was lost due to termination of employment (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of employee's hours of employment, Extended Coverage may last for only up to a total of 18 months. There are two ways in which this 18-month period can be extended.

1.) Disability extension of 18-month period of continuation coverage

You and anyone in your family covered under the Extended Coverage provisions of the Plan (due to termination of employment or reduction of hours) may be entitled to receive up to an additional 11 months of continuation coverage if it is determined by the Social Security Administration that any covered family member is disabled at some time during the first 60 days of continuation coverage and which lasts at least until the end of the 18-month initial period of continuation coverage. The Office of Health Benefits Extended Coverage Administrator (see page 4) must receive notification of the disability determination within 60 days of either 1.) the date of the disability determination; 2.) the date of the qualifying event; 3.) the date on which coverage would be lost due to the qualifying event; or, 4.) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice (e.g., through this General Notice), AND within the first 18 months of Extended Coverage. Notification must be presented in writing and include the following information:

- The name of the disabled qualified beneficiary;
- The date of the determination;
- Documentation from the Social Security Administration to support the determination;
- The written signature of the notifying party (qualified beneficiary or representative);
- If the address of record is incorrect, a correct mailing address.

2.) Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of Extended Coverage, the spouse and dependent children in your family can get up to 18 additional months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given (in the format and time frame specified below) to the Office of Health Benefits Extended Coverage Administrator (see page 4). The extension may be available to the spouse and any dependent children receiving continuation coverage if the employee/former employee dies, the employee/former employee becomes divorced from the covered spouse, or the covered dependent child ceases to be eligible under the Plan, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Written notification must be given within 60 days of the date coverage would have been lost due to the second qualifying event and should include the following information:

- The type of second qualifying event (e.g., divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse and/or dependent child);
- The date of the second qualifying event;
- Documentation to support the occurrence of the second qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support);
- The written signature of the notifying party;
- If the address of record is incorrect, a correct mailing address.

Failure to furnish timely and complete notification of the second qualifying event or disability determination will result in loss of additional Extended Coverage eligibility. Notice will be considered furnished when mailed or, in the case of hand delivery, the date it is received by your Benefits Administrator.

Separate guidelines apply to continuation coverage under the provisions of the Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA). If these provisions apply to you, see your Benefits Administrator for more information.

If you have questions:

Questions concerning your Plan or your Extended Coverage rights should be addressed to the contacts listed below under ***"Plan contact information."***

Keep your Benefits Administrator informed of address changes

In order to protect your family's rights, you should keep your Benefits Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Benefits Administrator or the Office of Health Benefits Extended Coverage Administrator.

The Plan Administrator is:

The Department of Human Resource Management

101 N. 14th Street, 13th Floor
Richmond, Virginia 23219

Plan contact information

For information about Extended Coverage, initial notification of qualifying events, and initial enrollment, contact your agency Benefits Administrator (see page 1).

To makes changes to Extended Coverage after initial enrollment, contact:

Office of Health Benefits Extended Coverage Administrator
101 N. 14th Street
13th Floor
Richmond, VA 23219
Telephone: 804/371-6436

Extended Coverage Election Notice
Date

Address this notice as appropriate to:

- ***The employee, or***
- ***The employee and spouse, or***
- ***The employee, spouse and family, or***
- ***The spouse or child who is losing coverage***

At the mailing address(es) of record

Dear ***(Name and/or Status of Qualified Beneficiary/ies)***

This notice contains important information about your right to continue your health care coverage in the Commonwealth of Virginia Health Benefits Program (the Plan). Please read the information contained in this notice very carefully.

To elect Extended Coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it, along with your Extended Coverage Enrollment Form, to the Benefits Administrator noted at the bottom of this page. Additional resources are included in the attachment, *Important Information About Your Extended Coverage Rights*.

If you do not elect Extended Coverage, your coverage under the Plan will end on ***(enter date coverage would be lost due to the qualifying event—see your Health Insurance Manual for information on concurrent leave without pay and long-term disability coverage)*** due to:

- ❑ End of employment
- ❑ Reduction in hours of employment resulting in loss of coverage (including loss of or change to employer premium contribution)
- ❑ Death of employee or retiree
- ❑ Divorce from the employee or retiree
- ❑ Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect Extended Coverage, which will continue group health care coverage under the Plan for up to ***(insert 18 or 36)*** months:

- ❑ Employee or former employee
- ❑ Spouse or former spouse
- ❑ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- ❑ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, Extended Coverage will begin on ***(insert date)*** and can last until ***(insert date)***. At the start of your Extended Coverage period, you may elect any of the plan options listed on your enrollment form.

Attached is a premium rate summary that provides the cost for Extended Coverage based on the elected membership level and plan. You do not have to send any payment with the Election Form. Important additional information about payment for Extended Coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to Extended Coverage, you should contact:

(Insert name, address and telephone number of the Benefits Administrator who should receive this election.)

Extended Coverage Election Form

INSTRUCTIONS: To elect Extended Coverage, complete this Election Form and return it to the Benefits Administrator listed on page one of this notice. By law, you must have 60 days after the date of this notice (or from the date that coverage is lost due to the qualifying event, whichever is later) to decide whether you want to elect Extended Coverage under the Plan.

This means that this form, along with a Commonwealth of Virginia Health Benefits Program Enrollment Form (enclosed), must be delivered to the Benefits Administrator by ***(insert end of 60-day enrollment period)***. An Election Notice and Enrollment Form that are mailed will be considered timely if postmarked by that date. If they are hand-delivered, they will be considered timely if received by the Benefits Administrator by that date.

If you do not submit a completed Election Form and Enrollment Form by the due date shown above, you will lose your right to elect Extended Coverage. (If you have elected an alternative coverage that runs concurrently with Extended Coverage, such as coverage while on leave or long-term disability, and that coverage will be exhausted before the end of the maximum Extended Coverage period available to you, see your Benefits Administrator for additional information.) If you decline Extended Coverage before the due date, you may change your mind as long as you furnish a completed Election Form and Enrollment Form before the due date. However, if you change your mind after first rejecting Extended Coverage, your Extended Coverage will not begin until the first of the month after you furnish the completed forms.

Be sure to read the important information about your Extended Coverage rights included in the pages following this Election Form.

I (We) elect or decline Extended Coverage as indicated below. If coverage is elected, please check whether you will continue Medical Coverage and/or Medical Reimbursement Account/MRA (if applicable):

Name	Date of Birth	Current ID Number	Social Security No.	Medical (√)	MRA (√)	Decline (√)
Employee						
Spouse						
Child						
Child						

If additional qualified beneficiaries should be listed, please attach a separate sheet.

**Signature _____ Date_____

Print Name _____
Relationship to person listed above_____

Print Address _____
_____

Telephone Number_____

*If the employee became entitled to Medicare (Part A or B) within the 18 months prior to termination of employment or reduction of hours, please indicate eligibility date here_____.

**A covered employee may elect coverage on behalf of his/her eligible spouse, and parents may elect on behalf of their eligible children. Indicate individual elections on the Enrollment Form(s).

IMPORTANT INFORMATION ABOUT YOUR EXTENDED COVERAGE RIGHTS

What is Extended Coverage?

Federal law requires that most group health plans (including this Plan) give employees/former employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, the covered employee's or former employee's spouse, and the dependent children of the covered employee or former employee. This includes children covered through a Qualified Medical Child Support Order (QMCSO).

Extended Coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects Extended Coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment, if applicable, special enrollment rights, and changes consistent with the qualifying midyear events listed in your handbook and on the Extended Coverage Enrollment Form.

Medical Reimbursement Accounts

Employees who are enrolled in a Medical Reimbursement Account may also choose to extend current participation in that program if, on the event date, the maximum benefit available for the remainder of the plan year is more than the maximum amount that the plan could require as payment for the remainder of the year. Continued contributions may be made to Fringe Benefits Management Company (address available through your Benefits Administrator) up to the last month of the plan year for which you are enrolled at the time of the qualifying event.

How long will Extended Coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment (including long-term disability, leave of absence without pay), coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's or former employee's death, the employee's or former employee's divorce, or the loss of dependent child status under the Plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, Extended Coverage for qualified beneficiaries other than the employee lasts up to 36 months from the month that Medicare entitlement occurred. It is the responsibility of the employee to advise the Benefits Administrator of Medicare entitlement within the 18 months before the qualifying event so that the appropriate duration of coverage may be

offered. This notice describes the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid on time (see **"When and how must payment for Extended Coverage be made?"**); or;
- A qualified beneficiary becomes covered, after electing Extended Coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary*; or,
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage*; or,
- A qualified beneficiary ceases to be disabled during the 11-month disability extension.*

Extended Coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving Extended Coverage (such as fraud).

*It is the obligation of the qualified beneficiary to notify the Office of Health Benefits Extended Coverage Administrator within 30 days of the start of coverage under another group health plan or Medicare after the election of Extended Coverage or loss of disability status during the 11-month disability extension. This should be sent in writing by a qualified beneficiary or representative to:

Office of Health Benefits Extended Coverage Administrator
101 North 14th Street, 13th Floor
Richmond, VA 23219

Upon report of other group health plan coverage or entitlement to Medicare, Extended Coverage will be terminated at the end of the month in which that coverage begins. Upon report of loss of disability status during the 11-month disability extension, Extended Coverage will be terminated the first day of the month that is more than 30 days after the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. Failure to report these events within the 30-day time limit will not preclude termination retrospectively to the date that coverage would have been terminated had the events been reported timely. Premiums paid during that period will be refunded, and any paid claims will be retracted.

Separate guidelines apply to continuation coverage under the provisions of the Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA). If these provisions apply to you, see your Benefits Administrator for more information.

(Benefits Administrators--Insert the following section if the period shown on page one of this notice is less than 36 months)

How can the duration of Extended Coverage be increased?

If you elect Extended Coverage due to termination of employment or reduction of hours, an extension of the 18-month maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Office of Health Benefits Extended Coverage Administrator at 101 N. 14th Street, 13th Floor, Richmond, VA 23219, telephone 804/371-6436, of a disability or a second qualifying event in order to extend the period of continuation coverage from 18 up to 29 or 36 months. Failure to provide timely notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage; however, one notice will cover all affected qualified beneficiaries.

o *Extension due to disability*

An 11-month extension of coverage may be available if any qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled at some time during the first 60 days of Extended Coverage and lasts at least until the end of the initial 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. Notification of the disability determination must be given to the Office of Health Benefits Extended Coverage Administrator (see above) within 60 days of either 1.) the date of the disability determination; 2.) the date of the qualifying event; 3.) the date on which coverage would be lost due to the qualifying event; or, 4.) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice (e.g., through the this notice or the General Notice), AND within the first 18 months of Extended Coverage. Notification must be presented in writing and include the following information:

- The name of the disabled qualified beneficiary (e.g., employee, spouse or dependent child);
- The date of the determination;
- Documentation from the Social Security Administration to support the determination;
- The written signature of the notifying party (qualified beneficiary or representative).

If the disability ends prior to the end of the 11-month disability extension, it is the responsibility of the qualified beneficiary or his/her representative to notify the Office of Health Benefits Extended Coverage Administrator at the address noted previously within 30 days of the loss of disability status by providing documentation from the Social Security Administration. Failure to report the end of the disability status within the 30-day time limit will not preclude termination retrospectively to the date that coverage would have been terminated had it been reported timely (the first of the month that is more than 30 days after the determination). Premiums paid during that period will be refunded, and any claims paid will be retracted.

o *Extension due to a second qualifying event*

An 18-month extension of coverage will be available to spouses and dependent children who elect Extended Coverage due to the employee's termination of employment or reduction of hours if a second qualifying event occurs during the first 18 months of

continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee/former employee, divorce from the covered employee/former employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Office of Health Benefits Extended Coverage Administrator if you want to exercise your rights to the additional Extended Coverage period. Written notification must be given within 60 days of the date coverage would have been lost due to the second qualifying event and should include the following information:

- The type of second qualifying event (e.g., death, divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse and/or dependent child);
- The date of the second qualifying event;
- Documentation to support the occurrence of the second qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support, death certificate);
- The written signature of the notifying party.

Failure to provide timely and complete notification of the second qualifying event will result in loss of additional Extended Coverage eligibility.

How is Extended Coverage elected?

To elect Extended Coverage, you must complete the Election Form and Commonwealth of Virginia Extended Coverage Enrollment Form and furnish it to the Benefits Administrator designated at the beginning of this package. Each qualified beneficiary has a separate, independent right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect Extended Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of Extended Coverage may help you avoid such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible

(such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event for which this notice was provided. You will also have the same special enrollment right at the end of Extended Coverage if you utilize the maximum period available to you.

How much does Extended Coverage cost?

Generally, qualified beneficiaries must pay the full cost of Extended Coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage. The required monthly payment for each continuation coverage period for each option is described in an attachment to this notice.

When and how must payment for Extended Coverage be made?

o *First payment for Extended Coverage*

If you elect Extended Coverage, you do not have to send any payment with the Election Form. However, you must make your first payment not later than 45 days after the date of your election. (If the Election Form is mailed, this would be 45 days from the postmark.) If you do not make your first payment within this time limit, you will lose all continuation coverage rights under the Plan. The first payment should include premiums for the period of coverage starting with the date coverage was lost due to the qualifying event and any regularly scheduled monthly premium that becomes due between your election and the payment date. You are responsible for making sure that the amount of your first payment is correct. You will receive a bill from the Extended Coverage billing agent (Anthem Blue Cross and Blue Shield or Kaiser Permanente HMO, as appropriate) to reflect the premium amount due, and you may contact the billing agent if you wish to confirm the amount of your bill and accompanying information.

o *Periodic payments for Extended Coverage*

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage month. The amount due for each coverage month for each membership level is attached to this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first of each coverage month. You will receive monthly invoices for premium payments.

o *Grace periods for periodic payments*

Although periodic payments are due on the first day of the coverage month, you will be given a grace period of 30 days to make each periodic payment. However, if your premium payment is not received by the first day of the coverage month, your coverage will be suspended and then retroactively reinstated (going back to the first day of the coverage month) when the premium payment received. This means that any claim you submit for benefits while your coverage is suspended may be denied, but it may be

resubmitted once your coverage is reactivated upon receipt of payment. If you fail to make your monthly payment by the end of the grace period (30 days after the start of the coverage period), you will lose all rights to continuation coverage under the Plan effective the first of the month for which payment was not received. Your premium payments should be sent to the appropriate billing agent as reflected on your monthly billing. Payments are considered made when mailed.

For more information

This notice does not fully describe Extended Coverage or other rights under the Plan. Questions concerning your Plan or your Extended Coverage rights should be addressed to the contacts listed below. For more information about your rights under the Health Insurance Portability and Accountability Act, contact the nearest regional or district office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa.

Contact information

- *For information about Extended Coverage, initial notification of qualifying events, and initial enrollment:*

  Insert Agency Benefits Administrator
  -Address
  -Telephone Number

- *To makes changes to Extended Coverage after initial enrollment:*

  Office of Health Benefits Extended Coverage Administrator
  101 N. 14th Street
  13th Floor
  Richmond, VA 23219
  Telephone: 804/371-6436

- *The plan administrator is:*

  Commonwealth of Virginia
  Department of Human Resource Management
  101 N. 14th Street, 13th Floor
  Richmond, VA 23219
  Telephone: 804/225-2131

Keep your plan informed of address changes:

In order to protect your and your family's rights, you should keep the Office of Health Benefits Extended Coverage Administrator informed of any changes in your address and

the addresses of family members that occur after initial enrollment. You should also keep a copy for your records, of any notices you send to either administrator listed above.

Attachments: HIPAA Certificate of Creditable Coverage
Premium Rate Information
Extended Coverage Enrollment Form

Benefit Administrators must furnish Certificates of Coverage automatically whenever coverage under the State Health Benefits Program ends for any reason. For example, certificates should be sent to:

• Any individual who is entitled to elect Extended Coverage when the Extended Coverage notification is sent, regardless of whether they elect Extended Coverage. (The appropriate carrier will provide a HIPAA Notice at the expiration of Extended Coverage.

• Any individual who loses coverage and is not eligible for Extended Coverage. For example, a voluntary reduction in membership i.e., as spouse obtains a job with his own benefits or a dependent is dropped at Open Enrollment.

• Any individual upon request if the request is made within 24 months after the individual loses coverage under the plan.

One notice may be sent to family members who are simultaneously losing coverage under the same contract and who live at the same address, but the notice should include individual names of all participants who are losing coverage. It is not necessary to send a Certificate of Coverage when a Medicare Supplement coverage is lost by a retiree group member.

A sample notice follows and is also available at the DHRM web site.

Commonwealth of Virginia
Certificate of Group Health Plan Coverage

Date of This Certificate: _____

Name of Participant: _____

Name of Health Care Plan: _____

Participant's Identification Number: _____

Membership Level (Single, Employee + One, Family): _____

Name of Individuals to Whom This Certificate Applies: _____

_____

Was the Period of Creditable Coverage More Than 18 Months? (Yes/No): _____
(Disregard periods of coverage before a 63-break.)

If Less Than 18 Months, Date Coverage Began: _____

Date Coverage Ended: _____

Date Waiting Period Began: __Not Applicable_____

Person preparing this certificate and to whom questions should be addressed:

Name: _____
Address: _____
_____
Telephone No: _____E-mail Address: _____
Agency: _____

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

Statement of HIPAA Portability Rights

This certificate is evidence of your coverage under the plan. You may need evidence of coverage to reduce a pre-existing condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems. This certificate, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is furnished to everyone leaving the State Health Benefits Program or the State Retiree Health Benefits Program (except for Medicare Supplement Plans). You may obtain additional certificates for you or your covered family members from your Agency Benefits Administrator (or the Virginia Retirement System for retirees) should you need them during the 24 months following your termination from the plan.

Pre-existing condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-

existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, Extended Coverage (COBRA), coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk with your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additionally, special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Rights to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;

- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for Extended Coverage (COBRA) or you have exhausted your Extended Coverage (COBRA) benefits; and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

For more information. If you have questions, you may contact the person who prepared this certificate (contact information included). You may also contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws) or the CMS publications hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at http://www.dol.gov/ebsa, the U.S. Department of Labor's interactive web pages – Health Elaws, or http://www.cms.hhs.gov/hipaa.

The following chart summarizes the deadlines for applying for coverage or making changes in membership.

If The Employee Applies	Coverage/Membership Change Becomes Effective
Within 31 days of Employment	The first day of the month coinciding with, or following receipt of the enrollment action, unless the election is received the first business day following the employment date. In which case the first of the month in which the employee begins employment. (Faculty—please refer to Section 6.1
Open Enrollment	July 1st
Within 31 days of a qualifying mid-year event change (see additional information on the following pages.)	The first of the month following receipt of the enrollment action. If the event is the first of the month and the enrollment action is taken at that time, then the effective date of coverage will coincide with the event. HIPAA allows for special enrollment rules in connection with a birth, adoption, or placement for adoption. Please see Section 2.2 for details. Additionally, the plan requires the termination of coverage resulting from certain events, such as divorce or a child reaching the limiting age. In these cases the employee has 31 days to reduce membership. This reduction

If The Employee Applies	Coverage/Membership Change Becomes Effective
	in membership will be effective the first of the month following the event.

Open Enrollment An employee will be able to change health benefits plans or membership and enroll in a flexible reimbursement account if otherwise eligible, during the annual Open Enrollment period. Open Enrollment for these plans is usually held in the spring with a July 1st effective date. These elections are irrevocable for 12 months unless the employee experiences a qualifying mid-year event as outlined in Section 3.2 and makes a consistent corresponding change within 31 days of the event.

New Employees Sometimes a new employee is provided continued health benefits by a previous employer for a limited period of time. The new employee may waive coverage initially and postpone enrollment in the State Group to the indicated time when the other coverage terminates. This is considered a special enrollment under HIPAA.

- All active employees whose contributions are payroll deducted pay health care premiums on a pre-tax basis.
- A new employee is eligible to enroll in a Dependent Care Reimbursement Account effective the same day that a health benefits membership becomes effective. However, there is no requirement that an employee be enrolled in health benefits to enroll in a Dependent Care Reimbursement Account. The enrollment must occur within 31 days of hire or qualifying mid-year event.
- A new employee will be eligible to enroll in a Medical Reimbursement Account when he has maintained 6 continuous months of eligibility for the health benefits program. The election period is the 31 days prior to his 6-month date of continuous eligibility for health benefits. Additionally, an employee may make or change an election if a qualifying mid-year event is experienced and the other eligibility criteria have been met.

  (For information on new employee eligibility for Medical Reimbursement Accounts, consult the Flexible Reimbursement Accounts Program Administrative Handbook.)

Faculty Enrollment Faculty members may have a total of 12 months coverage for a 9-, 10-, 11-month contract. Please refer to Faculty On 9-, 10-, Or 11-Month Appointments, Section 6.1.

Mid-year Events That Qualify You To Make A Change

An employee or retiree group participant may change his type of membership, plan or additional coverage option, if he applies to do so within 31 days of any of the qualifying mid-year events listed below. It is the employee's responsibility to enroll through EmployeeDirect (or submit an Enrollment/Waiver Form to the agency Benefits Administrator) within the 31-day time period. Failure to act within 31 days will preclude a change based on the mid-year event. Changes in membership or plan option that are consistent with the qualifying mid-year event will go into effect the first of the month coinciding with or following the timely receipt of enrollment notification, except:

- when the event is the birth/adoption or placement for adoption. In these cases coverage will be effective on the date of the event. However, administratively the effective date of coverage for the new child and any family members added due to the birth/adoption or placement for adoption will be the first of the month preceding the event.
- when a dependent becomes ineligible for coverage under the State program due to a divorce or child losing eligibility. In these cases coverage will cease the end of the month of the event.

All changes must be on account of and correspond with the qualifying mid-year events listed below. The only other time an employee may change an election is at Open Enrollment.

Qualifying Mid-Year Events

Employment Change that Affects Eligibility
- Employee begins leave without pay or family medical leave
- Employee returns from leave without pay or family medical leave
- Spouse or covered child gains employer eligibility (including switching from part-time to full-time employment)
- Spouse or eligible child loses employer eligibility (including switching from full-time to part-time employment)
- Spouse begins leave without pay
- Spouse ends leave without pay

Legal Marital Status Change
- Marriage
- Divorce
- Death of spouse

Medical Child Support Order
- A court has required that another party cover your children
- Judgment, decree or order requiring coverage of a child
- Social Services order requiring coverage of a child

Medicare or Medicaid Change
- Dependent gaining eligibility for Medicare or Medicaid
- Losing eligibility for Medicare or Medicaid

Number of Eligible Family Members Change
- Add newly eligible member to existing family coverage
- Adoption
- Birth
- Covered child ceases to be eligible (exceeds plan's age limit, marries, becomes self-supporting, etc.)
- Death of a covered child
- Permanent custody granted
- Remove family member prospectively

Other Loss of Coverage
- HIPAA special enrollment due to loss of coverage
- Losing eligibility under another government-sponsored plan

Special Coverage Costs Change
- Open Enrollment or significant change under another employer's plan

Enrollment Options

NOTE: If Family membership is elected due to a qualifying mid-year event, all eligible dependents should be added. Eligible dependents may not selectively be removed from a Family membership. Please refer to Section 4, Personal Changes, for more detailed information on specific qualifying mid-year events.

Enrolling Within 31 Days Of Employment

In order to have coverage an employee must enroll within 31 days of employment. Thereafter coverage may be secured if the employee experiences a qualifying mid-year event or during the Open Enrollment period. Coverage will be effective the first of the month coinciding with or following the enrollment action. However, if the employee's employment date begins on the first business day of the month and, if an election action is made that day, coverage for the employee will commence on the first day of that month.

It is the Benefits Administrator's responsibility to see that each new employee receives complete and timely health benefits and flexible benefits information.

NOTE: Please refer to the Flexible Reimbursement Accounts Program Administrative Handbook for information on the Medical and Dependent Care Reimbursement Accounts.

When a new employee wants to enroll, the following steps should be taken.

1. Determine whether:

   - The employee is eligible for membership in the State Health Benefits Program.
   - The employee wishes to cover a spouse and/or eligible children.
   - The new employee transferred directly from another agency. If so, the employee must be maintained in the current health benefits plan and membership unless the employee is moving in or out of the service area of a plan in which he or she is enrolled and needs to make a change in plan for that reason. A new Enrollment action will not be necessary unless a change in plan is allowed for moving in or out of the service area. A transfer of the Benefits Eligibility System (BES) record and the most recent Enrollment Form to the new agency of record is necessary. Follow the instructions provided in Section 5.6, Transferring Between Agencies. Employees who have a 30 day or more break in service should be treated as new employees and should be offered the complete menu of enrollment options.

2. Give the employee complete information about the health benefits plans and the cost of coverage. You may direct them to the DHRM Web site for the most current information regarding the State Health Benefits Program. The address is http://www.dhrm.virginia.gov/compandbenefits.html.

   Explain that monthly premiums will be collected through payroll deduction. Summer premiums for faculty at colleges and universities are incorporated in the premiums they pay during the other months of the year.

3. Inform the employee that all health benefit premiums are paid on a pre-tax basis. Also, advise the employee of the rules of eligibility for the Flexible Reimbursement Accounts.

4. Inform the employee about the self-service system. Once a new employee has an employment record on the Personnel Management Information System (PMIS), a "waived" record is created on the Benefits Eligibility System (BES). If a new employee is not a PMIS employee, the Benefits Administrator will need to set up the initial BES "waived" record. Once the initial record is established, the self-service system can be used to enroll initially and to make enrollment changes.

   If the employee enrolls by completing an Enrollment Form, establish the employee's enrollment record on BES as soon as the completed form is received. Retain the Enrollment Form in your agency file; the BES record will establish coverage on the plan's membership systems.

5. Advise the employee that he or she must provide information regarding coordination of benefits with other health benefits plans, if applicable.

6. Advise the employee of the limitations on eligibility for dependents and of the penalty that will be imposed if the employee is found covering an ineligible dependent.

7. If the employee submits a form, check to see that the employee fills in the form completely and accurately. Always check the Social Security number on the form with the employee's Social Security card to make certain it is correct. If a spouse and/or dependents are covered, make certain their Social Security numbers are listed. The only persons exempt from this requirement are certain dependents of foreign nationals. See Section 6.2 for expanded information on foreign nationals who are not eligible for a Social Security number. The Social Security Administration can provide a letter of denial to those not eligible for a Social Security number (SSN). DHRM will need to enter the BES records of affected persons. (Note: Newly acquired dependents can be added to BES for a period of 90 days with a temporary social security number. Once the permanent number has been obtained, the employee must submit the information to the benefits office and BES must be updated accordingly.)

8. Advise employees how to select a PCP if enrolled in a HMO by —

   - calling the HMO directly,
   - submitting a PCP Selection Form to the HMO,
   - or sending a letter by fax or mail to the HMO.

9. Tell the employee that the health benefits plan will send membership cards to his or her home address. The employee may check with the plan if the membership cards are delayed or if he notes an error on the cards.

10. Provide an Extended Coverage General Notice, appropriately addressed, within 90 days of the commencement of coverage. See Section 2.7 for more information about Extended Coverage.

11. See the Commonwealth's Accounting Policies and Procedures (CAPP) manual for payroll deduction instructions.

12. Once an employee has submitted an election, within 31 days of employment, that election is binding and may not change after it takes effect.

Enrolling More Than 31 Days After Employment

The procedures to follow are the same as for enrolling within 31 days of employment, except for the following steps:

1. If coverage is selected at a time other than in conjunction with an Open Enrollment period, the employee should certify over the self-service system or on the Enrollment Form the qualifying mid-year event, and give the date on which the event took place.

Reducing Membership

It is the employee's responsibility to use the self-service system or to submit to his or her agency Benefits Administrator a completed Enrollment Form to reduce health benefits membership when a previously eligible dependent loses eligibility due to contractual provisions in the plan. Reductions in membership or waiver of coverage can be made the first of the month following a qualifying mid-year event. Notification of the change must be made within 31-days of the qualifying mid-year event.

Changing Type Of Membership

1. The self-service system will be the method used for change in almost all instances. However, enrollment in the retiree group must be accomplished by Enrollment Form and manual entry into the Benefits Eligibility System (BES).

2. New membership cards will be issued by the health benefits plan administrators.

3. The health membership code on the employee's payroll record must be changed to the appropriate new code.

4. In the instance where a change is made using an Enrollment Form, record the change in membership on the BES record.

5. Once an employee has submitted an election, within 31 days of a qualifying mid year event, that election is binding and may not be changed after it takes effect.

6. Two state employees enrolled in family membership, with one covered family member, must reduce to an Employee Plus One membership if the dependent loses eligibility.

When an employee desires to waive health benefits membership, ascertain that the rules of the program allow the desired change such as a consistent qualifying mid-year event or Open Enrollment. Examples of events that allow participants to waive coverage include:

- Employee beginning leave without pay,
- Marriage if enrolling in the spouse's plan,
- Spouse begins employment if enrolling in spouse's plan, and
- Annual enrollment or change allowed under another employer's plan if enrolling in spouse's plan.

3.6 ENROLLMENT WHEN THERE IS A HEALTH CARE COVERAGE ORDER

The Department of Social Services now uses the National Medical Support Notice (NMSN). In compliance with the Code of Virginia, agencies are required to enroll in State coverage eligible dependents named in a Department of Social Services (DSS) NMSN. DSS is charged with enforcing these provisions and with notifying the employing agency of the requirement that the agency provide coverage. DSS will communicate the requirement for coverage through the Order/Notice to Withhold Income for Child Support. There is a section on this form where an agency will see an instruction to enroll a dependent in coverage. If this section is checked, proceed with the enrollment.

When an agency receives a NMSN from DSS, the agency must ascertain if the dependent referenced in the order is eligible for State health benefits, and take action accordingly, as follows:

- If the coverage order calls for the employee to cover a biological or adopted child, the order will apply to the State group, regardless of where the child resides. The eligible dependents must be enrolled in health benefits in accordance with the DSS coverage order, and proper notice to DSS must be given.

- If an order calls for the employee to provide coverage for an ex-spouse, or an ineligible dependent, the order will <u>not apply</u>, as these persons are not eligible for membership in the State group. If you ascertain that the employee or the dependent referenced in the coverage order is not eligible for membership in the State group, the agency must so notify DSS within 20 days of service of the order.

For dependents who are determined to be eligible, please observe the following procedures:

1. Assuming that National Medical Support Notices from the Department of Social Services are qualified, enroll the dependent(s) in coverage prospectively. For example if the order is received on June 21, then the child should be enrolled effective July 1.

    - If the employee currently is enrolled in a health benefits membership, add to the membership the eligible dependent(s) named in the NMSN. This may entail broadening the membership or changing plans to accommodate the newly added member(s). For instance, if the employee is enrolled in an HMO before receipt of the NMSN and the child lives out-of-state, the employee will need to enroll in COVA Care.

- If the employee currently is not enrolled in a health benefits membership, enroll the employee and the eligible dependent(s) in the employee's plan of choice, as long as the service area of the plan provides access for the child.

- If an employee refuses to sign an Enrollment Form to comply with a NMSN, the agency Benefits Administrator should enroll the employee and sign his or her own name where the employee would normally sign, and note beside the signature that the employee has refused to sign. Attach a copy of the coverage order to the Enrollment Form, and signify that the enrollment is being processed in compliance with the order. In this case, enroll the employee in COVA Care.

2. Deduct from the employee's earnings the applicable employee portion of premiums and establish the appropriate agency contribution.

3. Coverage orders from other states are to be processed in the same manner once a determination is made that the order is qualified. An order must contain the following information in order to be qualified:

   - The name and last known mailing address of the participant and each dependent to be enrolled in coverage;
   - A reasonable description of the type of health coverage to be provided; and
   - The period to which the order applies.

Handling Of A Health Care Coverage Support Order When The Employee Is On A Leave Without Pay (LWOP)

When an agency receives a coverage order for an employee who is on a leave without pay, the agency should establish the coverage as it would for any other employee, notifying the employee accordingly, as long as the employee is on a leave which qualifies for the Commonwealth's contribution. For example:

- In month seven of a personal leave without pay, the employee is not eligible for active employee coverage, and the order will not have bearing until the employee returns from LWOP.

- In month number three of sick leave without pay, the employee is eligible for coverage, and the coverage order must be observed.

Notify DSS when an employee on whom you receive a coverage order is on a LWOP. Also, notify DSS if the agency approves a LWOP for an employee who is currently under a coverage order. This will alert DSS that there may be an

issue with compliance, as the agency will have no paycheck from which to deduct premiums.

If the employee who is on LWOP fails to pay premiums and is canceled, notify DSS of the effective date of the termination of coverage. Once the employee returns to work, notify DSS and ascertain if the NMSN is still in effect. If so, establish the coverage as of the date the employee is eligible to re-enroll in the group.

The agency must promptly notify DSS if the employee named in a NMSN terminates employment

DSS Retraction Of Health Care Coverage Order

There may be instances where the DSS coverage order is retracted at a date after the coverage for dependents has been established. When this occurs, the agency should allow the employee to reduce coverage to eliminate the dependents, if he or she so desires. The effective date would be the first of the month following the DSS notice to the agency of retraction of the order. This notice constitutes a qualifying mid-year event and is subject to those rules.

As always, it is essential that State agencies cooperate in a timely fashion with a DSS NMSN.

4.1 GENERAL INSTRUCTIONS: WHEN THERE IS A QUALIFYING MID-YEAR EVENT

When an employee wishes to make a change in membership or plan option based upon a qualifying mid-year event, he must make the change within 31 days of the event. Coverage will be effective the first of the month coinciding with or following the date that the enrollment form is received or the change is made through the self-service system. Once an employee has submitted an election, within 31 days of the qualifying mid-year event, that election is binding and may not change after it takes effect. In cases of birth/adoption or placement for adoption, coverage will be retroactive to the first of the month in which the event occurred.

Additionally, the plan requires the termination of coverage resulting from certain events, such as divorce or a child reaching the limiting age. In these cases, the employee has 31 days to reduce membership and change plan options. These changes will be effective the first of the month following the event. Please note that the affected member is no longer eligible for coverage regardless of whether the employee has taken the appropriate action. However, the employee is responsible for making the reduction in membership. Thus, if the employee does not take timely action, the employee will be required to maintain the higher level membership.

In most instances, if an employee uses the self-service system to change membership or plan options, a BES pending transaction may be generated to the agency. The Benefits Administrator must review a pending transaction to determine if the change is in accordance with the program policies, and then either accept or deny the employee's requested change. By accepting a pending transaction, the change is entered into BES. Agencies will receive a BES turnaround document showing all changes processed by BES.

Coverage may be continued for a child who loses eligibility due to age if the child is incapable of self-support because of a severe mental or physical disability. The condition must have been diagnosed before he ceased to be eligible due to age. See Sections 4.7 and 4.8 for information on age limitations for dependent coverage.

There are times when a dependent will become ineligible for coverage under an employee's membership. When this does occur, the ineligible member must be eliminated from the employee's membership, effective the first day of the month after eligibility was lost. If the employee does not take this action timely, he risks removal from the program. These dependents will not have coverage, and the employee will not be allowed to reduce membership until the next Open Enrollment or qualifying mid-year event.

When a child loses coverage because he or she no longer is eligible, the child may enroll in Extended Coverage or non-group coverage with the health benefits plan in which he or she has been enrolled. The employee or the child must

contact the agency Benefits Administrator within 60 days of the loss of coverage for Extended Coverage, or must contact the health benefits plan to arrange for non-group coverage. Please refer to Extended Coverage eligibility information in Section 2.7.

The health benefits program rules allow the employee to change membership and plan in the event of a consistent qualifying mid-year event.

If an employee who had single membership marries and wants to add the spouse, the employee must enroll the new spouse within 31 days of the marriage. Documentation of the marriage must be provided in the form of a marriage certificate. Coverage will be effective the first of the month coinciding with or following notification. If enrollment does not occur within 31 days of the marriage, the employee may apply for Employee Plus One or Family membership during the next Open Enrollment period.

When an employee marries, the marriage creates a special enrollment period under HIPAA. The employee may enroll himself and all eligible dependents as long as the enrollment takes place within 31 days from the date of the marriage.

If the employee has Family membership and marries, the spouse may be added even after 31 days on a prospective basis. However, the spouse should be added immediately to avoid claim denials.

Separation, even with a property settlement, is not a qualifying mid-year event. All eligible family member(s) should be covered by the contract of an employee with a Family membership. Thus, such an employee may not eliminate selectively from coverage a spouse from whom the employee is separated or other eligible family members.

When the spouse of a State employee is eliminated from an employee's membership due to divorce, the spouse may be covered on the employee's membership only until the end of the month in which the divorce becomes final. The change can be made through the self-service system or through submission of an Enrollment Form. If the divorce causes a change in membership, the employee's premium will be reduced the first of the month following the event provided that notification is made within 31 days of the event. Note that coverage terminates the first of the month following the divorce. However, if the employee does not make timely notification of the divorce, the employee will not be allowed to reduce membership until the next Open Enrollment or qualifying mid-year event, whichever occurs first. The agency should obtain a copy of the final divorce decree from the employee giving the date of divorce, the ex-spouse's name, Social Security number, and address. If the agency is notified in writing in a timely fashion of the divorce, the agency is required to send the spouse an Extended Coverage notice. If the agency is not notified within 60 days, the agency has no obligation to offer Extended Coverage.

If Family membership is to be retained, the self-service system can guide the employee through the process of removing a dependent. Or, a new Enrollment Form can be filed to remove the spouse's name from the list of dependents. If a form is submitted, terminate the divorced spouse's record on the Benefits Eligibility System (BES), effective the last day of the month of the divorce. You must offer Extended Coverage.

If two State employees divorce and there is a dispute over who will carry the coverage for the children, the earlier membership covering the children will remain the membership of record.

Failure to remove an ineligible person from a state plan may result in the employee being removed from the plan for up to three years.

If the death causes a change in membership, the employee's premium will be reduced the first of the month following the death provided that notification is made within 31 days. The benefit administrator should obtain documentation of the dependent's death such as newspaper articles or obituaries. It is not necessary to get a copy of the death certificate.

If the employee fails to make a timely change in membership, the plan will consider this a clear and convincing error as defined by the IRS, and will allow the employee to reduce membership once the error is discovered. Premiums should be returned to the employee and employer up to the first of the year in which the error is discovered. Please assist your employees so that this important, but easily overlooked, membership change can be made.

An employee may broaden or reduce or plan options if there is loss or gain of the dependent's health benefits coverage due to a qualifying mid-year event.
Also, this applies when a State employee must make a change in enrollment because an ex-spouse or a dependent's other biological or adoptive parent loses employer coverage.

If an employee wishes to add a dependent who has lost coverage elsewhere, a certificate of coverage should be obtained from the former plan. The BA in lieu of the certificate may contact the former employer and verify the date the coverage was lost. The BA should document in her notes who and when she spoke to the former employer and attach such documentation to the employees enrollment form.

4.6 BIRTH/ADOPTION, OR PLACEMENT FOR ADOPTION OF A CHILD

If the employee enrolls a child within 31 days after the birth/adoption or placement for adoption, Employee Plus One or Family membership will be effective the first of the month in which the event takes place. The following documentation should be obtained and placed in the employee's file. For the birth of a child the BA should obtain a copy of the birth certificate or some other documentation validating the date of birth. For the adoption or placement for adoption, the BA should obtain court papers. Remember, DHRM must approve all pre-adoption agreements.

Adding a child to coverage will, in most case, require the collection of additional premiums. If family membership already exists, the child can be added at any time retroactive to the date of birth.

A child who is either adopted by a State employee, or who resides with the employee under the authority of a formal pre-adoptive agreement, will be eligible for health benefits in a manner identical to a biological child of an eligible employee. Within 31 days of the pre-adoptive placement or adoption effective date, the employee should take action to cover the adopted child, if coverage is desired. A pre-adoptive agreement is a document that states an authoritative body (such as a court of law, a licensed adoption agency, or DSS) is placing a child in the home of an individual under the supervision of that authority. The authority oversees the placement to ascertain if this would be a suitable permanent adoptive home for the child.

Children who are placed for adoption under a private arrangement will not be deemed eligible for coverage under a State employee's membership until a court of law transfers legal custody to the prospective adoptive parent(s). The court of law serves as the authoritative entity in the case of a private pre-adoptive placement.

DHRM must determine that a pre-adoptive agreement meets uniform eligibility standards. This determination is made at the sole discretion of the DHRM, which must review all related documents and authorize the enrollment of the child before coverage is effective.

A child who is adopted or is living with the employee under a formal pre-adoptive agreement (which has been approved by DHRM for the purpose of affirming eligibility), will be eligible for coverage, effective the actual date of adoption or pre-adoptive placement. As with adding newborns, the membership change will be effective the first of the month that the event takes place. As in the case with all qualifying mid-year events, the enrollment must occur within 31 days of the event for the coverage to be effective.

4.6 BIRTH/ADOPTION, OR PLACEMENT FOR ADOPTION OF A CHILD

Under the Health Insurance Portability and Accountability Act, employees may enroll themselves and other eligible family members when there is a birth/adoption or placement for adoption of a child. Coverage is effective the date of the event. The practical effect of adding a child or other family members as of the date of adoption or pre-adoptive placement is that, if membership must be broadened, the change to Anthem's system must occur retroactive to the first of the month of the event. Thus, the Benefits Administrator must notify Anthem or Kaiser that claims may be processed for services occurring on or after the event date (birth/adoption or placement for adoption).

In some cases an employee may want coverage for a newborn or child who is adopted or placed for adoption to be effective the first of the month following the birth/adoption or placement for adoption. The plan will allow this election, so long as the employee can provide documentation that the child has other coverage during the month in question, and such election is made within 31 days of the event.

An employee's unmarried children who are eligible to be claimed on the employee's or spouse's federal income tax may be covered on the employee's membership until they lose eligibility due to age. Eligible children may be covered until the end of the calendar year in which they turn age 23, regardless of student status. See section 4.8 on continuing coverage for incapacitated children.

Dependent children losing eligibility will automatically be removed from coverage as of January 1st each year. If the loss of a dependents eligibility due to age results in a change in membership, that change will be made systematically by DHRM.

DHRM reports to agencies in their FTP folder, listing employees whose BES records indicate that they have enrolled dependents who are losing eligibility due to age. The agency sends, in a timely manner, a notice to those employees about the impending loss of eligibility. DHRM supplies the model notice for agency use.

For, COVA Care, the request for continued coverage for a disabled child must be submitted to the Plan administrator within 31 days of the child losing eligibility due to age. Insured plans and HMOs usually require application and proof of incapacitation prior to the child losing coverage. Please note that approval may often be a time consuming process. Thus, employees should be encouraged to make application well before coverage terminates. In most cases, the certification is good for only one year and will require re-certification annually.

In order to begin the process, an employee should contact the customer service unit of the plan in which they are enrolled.

If an adult child who has been determined incapable of self-support later becomes capable of self-support, it is the employee's responsibility to terminate the child from his membership within 31 days of the change in status. Once a disabled dependent is removed from coverage due to recovery, and after eligibility for the program would normally be lost (end of the year in which the child turns age 23) the disabled dependent cannot be re-enrolled in the program should the child become disabled again.

When a child loses coverage because he no longer is eligible, the child may enroll in Extended Coverage or non-group coverage with the health benefits plan in which he has been enrolled. The employee or the child must contact the agency Benefits Administrator in writing, within 60 days of the loss of group coverage to enroll in Extended Coverage, or must contact the health benefits plan to arrange for non-group coverage.

New Employees with Disabled Dependents

When a new State employee wishes to provide coverage for an adult disabled dependent upon enrollment in State health benefits, the following conditions must be met:

1. The employee must provide evidence that he or the other parent has provided coverage for the dependent from the onset of the disability.
2. The onset of the disability must have occurred before the end of the year in which the child became age 23.
3. The plan must approve the condition as disabling.
4. The employee must apply to enroll the child within 31 days of the hire date or within 31 days of the date the child is no longer eligible to be covered by the other plan.

Eligibility for a dependent child stops at the end of the month in which the child marries. The employee must make an enrollment action to remove the child within 31 days of the marriage providing a copy of the marriage certificate. Regardless, coverage will terminate at the end of the month the marriage took place. However, if the employee does not make timely notification, the employee will not be allowed to reduce membership until the next Open Enrollment or qualifying mid-year event, whichever occurs first The child may enroll in Extended Coverage if written notice to the agency BA is timely. Additionally, a child may purchase non-group coverage it requested form the plan administrator within 31 days of termination of coverage form the state plan.

If an otherwise eligible child is no longer eligible be claimed on the employee's or spouse's income tax, he becomes ineligible for coverage under the Plan at the end of the month in which the child loses this IRS dependent status. It is the employee's responsibility to terminate the child from his membership within 31 days from the time the child loses legibility. Refer to Section 2.4, Types Of Membership, for more information.

If a dependent child terminates employment and subsequently becomes eligible to be claimed on the employee's or spouse's federal income tax return- and otherwise meets the plan's eligibility rules, the child may be added to the employee's membership within 31 days.

The BA should obtain a certificate of coverage from the dependent's former plan. In lieu of the certificate the BA may contact the former employer and verify the date the coverage was lost. The BA should document in her notes who, and when she spoke to the former employer, and attach such documentation to the employees enrollment form.

An otherwise eligible dependent may be added to an existing Family contract. The effective date for coverage will be no earlier than the date that the dependent became eligible. Please contact the Plan administrators to let them know the date of eligibility so that claims may be processed accordingly. In the case of adoption or placement for adoption, the effective date may not precede the actual date of placement in the home.

Anytime that the agency receives an Enrollment Form, please verify that the address on the form is the same as that on BES. If a new address is present, please update the BES record.

Please let your employees know that it is important to keep the agency and the plan informed of name or address changes. Encourage employees to make these changes using EmployeeDirect.

Medicare is a health insurance program for most people age 65 and older and some people under 65 who are disabled or have end-stage renal disease. It is a Federal Government program administered by the Centers for Medicare and Medicaid Services (CMS). Active employees or their covered dependents who are Medicare-eligible may elect Medicare as their primary coverage and leave the State Group, or they may elect to continue full coverage in the Active Group. Active employees who maintain coverage under the state plan and Medicare will have Medicare as their secondary coverage. However, employees who elect to remain in the Active Group may defer enrollment in Medicare Part B until retirement or other loss of coverage based on current, active employment. See Section 2.5 for additional information and discussion of exceptions due to End Stage Renal Disease.

Upon enrollment as a retiree, long-term disability participant or survivor, State Retiree Health Benefits Program participants must enroll in a plan that coordinates with Medicare. See Section 5.7 or Retiree Fact Sheet #5 for additional information about the coordination of Medicare and the State Retiree Health Benefits Program.

How To Enroll In Medicare

Contact the Social Security Administration for detailed information about eligibility and enrollment in Medicare. Individuals should contact Medicare three months before their 65th birthday month if they wish to have Medicare immediately upon eligibility due to age.

- Social Security – 1-800-772-1213 or www.ssa.gov
- Medicare – 1-800-MEDICAR or www.medicare.gov

As long as an employee is still receiving full pay, health benefits coverage continues automatically with the State making its contribution. No action is required to maintain coverage. Flexible benefits elections will be maintained through the end of the plan year.

An official educational leave is a leave for educational reasons with partial or full pay maintained for the leave, *not for work rendered*. It is possible to maintain health coverage on an educational leave provided that at least half pay is given. Coverage may continue for the duration of the leave up to 24 months. The State's contribution continues.

The employee on this type of leave should not be confused with the employee who reduces his or her work schedule for educational purposes. The latter situation is addressed in Section 5.5, Changing Employee From Full-time to Part-time.

Coverage with the State contribution continues to the end of the month in which the leave without pay (LWOP) begins, providing the first day of the leave is after the first work day of the month. Thus, if leave without pay begins on or before the first work day of the month of March, coverage with the State contribution ceases on the first calendar day of March.

The BA should request the following documentation when an employee goes on leave without pay or FMLA:

- FMLA request form
- P3 Personnel Action Form
- System documentation
- Extensions requires additional documentation
- No documentation required for return to work.

LWOP is a qualifying mid-year event. Thus, participants may make reductions in membership or waive coverage within 31 days of going on LWOP.

General Information

If the person who is on LWOP for any portion of a month, returns from leave the following month, and works at least half of the workdays in the month, regular coverage will be continuous.

The information found on the next several pages explains the policies and procedures for continuing health benefits coverage during LWOP.
If the LWOP extends beyond the end of the month when continuous active group coverage would cease, it is possible for an employee to maintain coverage under Extended Coverage. An Extended Coverage notice must be given prior to the start of LWOP. Please see Section 2.7, Extended Coverage, for important instructions.

Paying Premium	Employees on LWOP must pay their premiums (with or without a State contribution) timely. Premiums are due the first workday of the month of coverage. If a premium is not received timely, notify the employee in writing that there is a grace period of 30 days from the first of the month when the total premium was due. If the premium becomes over 30 days past due, terminate the coverage. Once terminated, coverage will not be reinstated for the duration of the leave without pay. If health benefits are terminated for non-payment and the employee is on unpaid leave for less than 30 days and subsequently returns to work, the employee must return to the same plan, and membership level in which he was enrolled prior to the leave. If health benefits are terminated for non-payment and the employee is on unpaid leave for more than 30 days and subsequently returns to work, the employee may make an election to enroll in a plan and select a membership level if the election is made within 31 days of returning from leave.

The agency must perform the waiver transaction on the employee's Benefits Eligibility System (BES) record if coverage is waived for the period of the leave. Upon the employee's return to work, verify that all information on the BES record is correct. Re-enter the employee into the active group.

Changes While On Leave Without Pay

Beginning LWOP is a qualifying mid-year event which allows consistent changes in membership and plan changes within 31 days of beginning the leave. Rules concerning changes in coverage and or membership while on leave without pay are the same as those followed by active employees i.e. Open Enrollment or if a consistent qualifying mid-year event is experienced.

NOTE: If the employee is enrolled in a Flexible Reimbursement Account, advise him or her of the rules for LWOP found in the Flexible Benefits Administrative Manual.

Reasons For Leave Without Pay

There are varying benefit periods for persons who are on LWOP, depending upon the reason for the leave. The chart found below shows under what conditions coverage may continue, whether the State contribution continues, and the length of time active employee coverage may extend while on LWOP.

When an enrollee who is on LWOP terminates while still covered by the State health benefits plan, (and prior to the end of the applicable Extended Coverage period of coverage), Extended Coverage must be offered for the remainder of the months available under the 18-month provision.

The fact that a LWOP may be "conditional" does not increase or decrease the coverage available in any of the categories shown below. The same rules apply whether or not the leave is conditional, and whether or not the leave changes from one to another type.

COVERAGE DURING LEAVE WITHOUT PAY

Type Of Leave	Coverage May Continue	Commonwealth Contribution
Personal	6 months	No
Educational*	24 months	No
Temporary reduction of work force	690 hours in 365 day period	Yes
Layoff	12 months	Yes
Sick Leave (a portion of which may be LWOP under the Family Medical Leave Act)	12 months	Yes
Military Leave (Active Duty)**	0 months	No

Type Of Leave	Coverage May Continue	Commonwealth Contribution
Suspension Pending Reinstatement	12 months	No

* This leave should not be confused with an educational leave with full or partial pay.

** Employees who are on active military duty, and their dependents, are eligible for Extended Coverage. If Extended Coverage is elected the state will continue to make its regular contribution during this 24-month period.

Personal Leave Without Pay

Active employee coverage may be continued at the employee's full expense during a personal leave without pay for up to six months.

Educational Leave Without Pay

This is leave for educational reasons without any pay during the leave. If a person works part time, and is paid for the work, the pay does not make him or her eligible for the official educational leave with full pay. Coverage may be continued for up to 24 months. There is no State contribution during the leave. Please note the difference between official educational leave (with pay) and leave for educational purposes (without pay).

Temporary reduction of work force

Permits agencies to reduce employees' work hours and pay temporarily or to place employees in a non-working status temporarily. Such reductions are limited to no more than 690 work hours in a 365-day period (for full-time employees) and cannot be imposed on an employee in successive years. Health care coverage with the State's contribution continues for the duration of the temporary work force reduction.

Leave Without Pay/Layoff

A person is placed on this type of leave without pay if laid off because of a work-force reduction, reorganization, or a job being abolished. Coverage may continue for up to 12 months, with the State's contribution continuing at the same rate as for the full-time classified employee. Please note that when an employee is laid off for any of the above reasons, Extended Coverage should begin following the end of the 12-month period.

The employee whose full-time classified position is reduced to permanent part-time due to work-force reduction, reorganization, or job abolition is considered to be in the layoff leave without pay category insofar as eligibility for health benefits is concerned. Thus, the state should continue its contribution toward the health care plan for up to 12 months. If the employee is offered recall to full-time employment and he or she does not accept, the state's contribution toward the health benefits plan will terminate the last day of the month in which

the recall was offered. If the employee is working 20 or more hours per week he should be offered the opportunity to enroll in the health benefits plan as a part-time employee.

Military Leave

Health benefits coverage through the United States government is free for military personnel on active duty and their dependents. Also, Extended Coverage is available to employees on military leave without pay and their covered dependents, with the state continuing to make its regular contribution for up to 24 months (the 2 % administrative fee will not be charged). Each covered family member is a Qualified Beneficiary. Employees returning from military leave without pay of more than 30 days have the full menu of health benefit choices (plan and membership). If the employee returning from a military leave without pay applies for coverage within 31 days of reinstatement, the coverage will begin either the first day of the month of reinstatement or the first of the following month, whichever is necessary to effect continuous coverage.

If employees are on military leave with pay, coverage continues automatically with the State making its contribution. Nothing must be done to maintain coverage.

Family Medical Leave Under The Provisions Of The Family Medical Leave Act (FMLA)

When an employee is on leave under the provisions of the FMLA, coverage with the Commonwealth's contribution will continue for the duration of the leave without pay up to a period of 12 weeks. The leave without pay may or may not occur concurrently with sick leave without pay. Two premium payment options may be offered to persons taking leave without pay under the FMLA:

1. Prior to the commencement of FMLA leave without pay, an employee may pay the premiums due for the FMLA period on a pre-tax basis from any taxable compensation; however, the employee may not pre-pay premiums for the next calendar year, if the leave will span two calendar years.

2. Under a "pay-as-you-go" option, an employee may pay his share of the premium on the same schedule as payments would be made if the employee were not on leave without pay. These payments are on an after-tax basis.

Sick Leave Without Pay

Most employees are now covered under the Virginia Sickness and Disability Program (VSDP). However, there continues to be some employees covered under the prior sick leave program. This section contains rules for employees covered by that prior program. When an employee is on LWOP due to sickness or injury, the agency must obtain physician certification of the illness or injury in order to handle the leave without pay as sick leave for purposes of continued health benefits coverage. Active employee coverage may continue up to 12 months with the State's contribution. This 12-month period includes any

combination of LWOP and any part-time hours worked that are allowed by a physician as part of a transition to full-time employment.

Disability Certification Form

To maintain the State contribution (and to allow coverage beyond the six months available to employees on a personal leave without pay), give the employee or, if necessary, a member of the employee's family, a copy of the *Disability Certification Form*. At the same time, notify the employee or family member in writing of the date the form must be completed and returned to you. (See the sample letter and form included in this section.)

The form should be returned by the first work day of the first full month of sick leave without pay. If the physician certifies that the employee will never be able to return to work full-time, no later certification is necessary to maintain the State contribution. The contribution may continue for up to 12 months if the person is on LWOP for that period. When the physician indicates a date that the employee is expected to return to full-time work, the certification will be effective up to that date. If the employee does not return by that date, a new Disability Certification Form must be submitted to the agency. If no new certificate is submitted, health care coverage during sick leave without pay cannot be maintained beyond the end of the month through which the employee was certified as disabled.

If the physician expects the employee to be able to return to work, but the date is not predictable, certification must be submitted to the agency every 60 days in order to maintain the State's contribution and to retain coverage beyond six months (the amount of time allowable for personal leave without pay coverage).

If the physician indicates that the employee is able to work part-time and no part-time employment is available, coverage may continue as for a certified sick leave without pay.

A letter from the doctor can serve in place of the certificate if it gives all the necessary information. The Disability Certification Form should be kept in your agency files.

If certification is not received by the first day of the first full month of sick leave without pay, send a letter to the employee stating the following:

1. The Disability Certification Form has not been received;

2. Unless the Disability Certification Form is returned by the end of the month, and any applicable premiums for the month are paid, coverage will be terminated retroactively, to the first day of the first full month of sick leave

without pay. (Also, note in the letter the final deadline for receiving the form.)

3. Without the Disability Certification Form, coverage may be maintained for up to six months, as on a personal leave without pay. However, the full monthly premium must be paid by the employee in advance. Give the date the premium is due (the same date the form is due).

A sample letter is found in this section.

If certification is not received by the final deadline, the State will discontinue its contribution, and, if personal leave without pay is granted for the period, coverage should be allowed as with personal leave without pay. One exception is if an employee is known to be hospitalized and the agency is unable temporarily to obtain certification. In that case, the State contribution may continue.

Sample Letter

Send in advance of first full month of leave without pay

Name

Dear _____:

The state will continue to contribute toward your health benefits coverage while you are on leave without pay or working reduced hours provided the following conditions are met:

- *You submit a Disability Certification Form completed by your doctor which provides information about your inability to work, and*
- *You make premium payments for your health care when they are due.*

Your coverage may continue in the group with the state contribution continuing for the period of time that your doctor certifies your disability not to exceed 12 months whether you are on leave without pay or working reduced hours. If your doctor is not certain when you can return to full-time work, a new Disability Certification Form must be submitted every 60 days for your coverage to continue. It is your responsibility to submit the Disability Certification Form to this agency. Any extension of health benefit coverage will run concurrently with coverage that would have been provided by Extended Coverage (COBRA).

Please give the enclosed Disability Certification Form to your doctor to complete. The completed form must be returned by (1st day of 1st full month of leave without pay) in order for you to receive the state's contribution toward the cost of your health care coverage. If the Disability Certification Form is not returned by the above date, you must pay the full cost of monthly coverage in advance and your coverage will not continue beyond six months while on leave just as with a personal leave without pay.

You are enrolled in plan and option, _____ membership at a monthly cost to you of $_____. Your first payment of $_____ is due on _____ and on the first of each month thereafter. Please send the payment to (Name of person, agency name and address) and make your check payable to the Treasurer of Virginia. If you do not submit a Disability Certification Form, the monthly cost to you will be $_____. Premium payments must be made timely. Coverage will be canceled retroactively to the last full month for which payment was received and recovery of funds paid on claims will be retracted if payment is not received by the date noted above.

You may reduce your membership or waive coverage during the period of leave without pay. Within 31 days of beginning the leave without pay, submit your request by using EmployeeDirect or notifying this office and submitting an Enrollment Form.

Please feel free to contact me at (phone number) if you have questions.

Sincerely,

Disability Certification Form
Commonwealth of Virginia Health Insurance Program

TO BE COMPLETED BY EMPLOYEE'S AGENCY

To the attending physician of _____
(Employee's Name

The above employee is a _____ employed by
(Job Title)

_____
(Name of Employing Agency)

_____
(Name and Address of Benefits Administrator)

EMPLOYEE RELEASE INFORMATION

I authorize the release of the requested information as may be necessary to certify my disability for the purpose of maintaining my State health benefits contribution.

_____
Employee Signature

This form must be returned to the person named above no later than _____ in order to keep this employee's insurance in force. Your cooperation is appreciated.

1. First examination _____ Most recent examination _____
   Month / Day / Year Month / Day / Year
2. Diagnosis/Complications of the employee's ☐ illness, ☐ injury, or ☐ pregnancy:

_____

_____

3. If applicable, please indicate the date surgery was performed or the expected date of delivery if the diagnosis is pregnancy:
   Type of Surgery _____ Date _____ Pregnancy: Expected Delivery Date _____
4. Please advise how the disabling condition affects the employee's return-to-work status: (check one)
   - ☐ This employee will not be able to return to full-time work in the future.
   - ☐ This employee will be able to return to full-time work on _____
     Month / Day / Year
   - ☐ This employee will be able to return to work but the date is unpredictable.

_____ _____
Signature of Attending Physician Date

_____
(Please Type or Print Name)

Note to Benefits Administrators: This form may be given to the employee or mailed directly to the attending physician. The form must be returned by the first work day of the first full month of leave without pay.
STFM 82180000 (3/94)

Sample Letter
Send during the first week of the first full month of sick leave without pay if the agency has not received the employee's completed Disability Certification Form.

Name

Dear_____:

On (date), I sent you a letter explaining that the State contribution toward your health care coverage cannot continue without a Disability Certification Form completed by your physician stating that you are unable to work. I have not received the necessary documentation.

Enclosed is another Disability Certification Form. The completed form and your check for health care coverage continuation are due to the agency by (the last day of this month). Please make your check payable to the Treasurer of Virginia. With the receipt of the Disability Certification form, the amount due for your membership type is $_____. If you do not return the completed Disability Certification Form, you may continue coverage by paying the total monthly premium amount of $_____.

Failure to pay your health care premiums when due will result in cancellation of your health care coverage retroactive to last full month for which payment was received. If coverage is canceled for non-payment, any claims paid after the cancellation date will be retracted.

Please contact me at (phone number) if you have questions.

Sincerely,

Collecting Premiums

Employees should pay the agency premiums the first of each month of coverage. Checks should be made payable to "Treasurer of Virginia" and deposited in the agency's General Ledger Account 902 (GLA 902). Participants have the option of paying health care premiums for the period of LWOP, on a pre-tax basis in a lump sum, from the last paycheck before beginning the leave. Participants have the option of paying health care premiums for the period of LWOP on a pre-tax basis in a lump sum from the last paycheck before beginning leave.

If Premiums Are Not Paid

If the employee will be unable to pay premiums for coverage of family members while on LWOP, he may reduce his membership or waive coverage within 31 days of taking LWOP by submitting a completed enrollment action.

If the employee fails to pay premiums timely while on LWOP, the employee and covered members will be removed on the last day of the month for which a premium has been paid. Notify the employee in writing that coverage has been terminated because of non-payment. Give the date coverage ended. Also, update BES and notify the agency payroll office.

Terminating Service While On Leave Without Pay

If an employee on a LWOP notifies your agency that he is terminating employment, active employee group coverage must stop at the end of the month in which the termination occurs. Do not remove the employee from the State Group retroactive to the last month the employee worked. Extended Coverage should have been offered when the leave was initiated. If it was not, it must be offered now. However, the full 18 months should not be authorized. Rather, the Extended Coverage period is 18 months minus the months of LWOP. You should enter the correct BES termination date prior to the termination being entered into PMIS to avoid cancellation of health benefits retroactively to the last day the employee worked. See section 2.7 concerning Extended Coverage and how it runs concurrently with coverage offered during leave without pay.

Removing Employee When No Longer Eligible For Group Coverage

If an employee has been continued in the State Group for the maximum time allowable while on LWOP, you must follow these steps to terminate coverage in the Group even if the leave continues.

1. Inform the employee in writing (30 days prior to removal) that he or she is being removed from the active employee group and give the date coverage ends.

2. If Extended Coverage was offered prior to the initiation of LWOP, as should be the case, , notify the employee of the remaining time available under Extended Coverage.

3. Inform the employee that it is possible to convert to non-group coverage once Extended Coverage is no longer available. The employee must contact the health benefits plan to enroll in non-group coverage. Application to the plan for conversion to non-group coverage should be made within 31 days of losing State coverage. Furthermore, if the employee has at least 18 months of creditable service as defined by HIPAA, the employee may have certain additional rights which may be exercised when securing individual coverage. Employees should be advised that insurers that offer individual health plans in the Commonwealth must recognize creditable coverage so long as the employee has at least 18 months of creditable coverage and received their most recent health coverage under an employer-related group health plan.

Taking A Second Leave Without Pay

If an employee returns from a LWOP and works full-time for at least one full month before taking another LWOP, the second leave will be treated as a new leave for the purposes of determining the benefit period for the LWOP.

If there is less than one month of full-time employment between leaves without pay, the leaves will be treated as one, regardless of the types of leave. The length of time that coverage may be continued during the second LWOP will depend on the benefit period allowed for that type of leave. The benefit period of the first leave accrues to the benefit available under the second leave.

Example 1: If an employee takes four months of personal leave and then becomes disabled and is changed to sick leave without pay, the employee may be allowed to continue coverage for up to eight more months, giving a total of 12 months of coverage (the number allowed for sick leave).

Example 2: If the employee takes four months of sick leave and then takes a personal leave, coverage could continue for another two months, giving a total of six months of coverage (the number allowed for personal leave without pay).

If the employee has maintained coverage while on leave without pay, the employee's coverage in the State Group with the State making its contribution will begin on the first of the month following the month in which the employee returns to work, However, if the person was on LWOP for only a portion of the previous month, returns from leave the following month, and works at least half of the workdays in the month, regular coverage with the state contribution will be continuous. It is not necessary for the employee to file a new Enrollment Form.

In the case of a qualifying mid-year event while the employee was on LWOP, the employee must take action to change enrollment within 31 days of the event for a change in membership to be effected. (See Section 4, Personal Changes.)

If the employee has not maintained coverage while on leave, the employee must take action to renew coverage upon his return to active employment. If an employee is gone 30 days or less, he must re-enroll is the same plan as he had immediately prior to the leave. If the leave exceeds 30 days the employee may select any plan or membership

Employees Returning From Military Leave For Active Service

Employees returning from military leave of thirty days or more have the same choice of coverage as a new employee. If the employee returning from a military leave applies for coverage within 31 days of discharge, the coverage will begin either the first day of the month of discharge or the first of the following month, whichever is necessary to effect continuous coverage.

Although classified part-time employees are eligible for the state health benefits plan, they do not receive any contribution from the state toward the cost of that coverage. Employees in classified full-time positions may temporarily reduce their hours and maintain the state's contribution if the reduction is because of:

- Illness or disability (certified)
- Educational purposes
- Temporary Work Force Reduction

The position must continue to be a full-time classified position. Employee status would be changed to part-time during the period that the hours are reduced to below 32 hours per week. (Sick and annual leave would be earned on a prorated basis.)

The following chart shows under what conditions health coverage may continue. If the employee changes from a leave without pay to working reduced hours or vice versa, follow the instructions for determining the length of time coverage may continue when an employee takes a second leave without pay, Section 5.3, Leave Of Absence Without Pay.

Also, see Section 5.3 regarding sick leave without pay for instructions on certification of disability. If a doctor certifies that an employee can work only part-time and the agency cannot offer part-time employment, coverage may continue as for a certified sick leave without pay.

Temporary Reduction of Hours

Reason	Length of Time	State Contribution
Illness (certified) including Family Medical Leave Act	12 months	Yes
Educational purposes	12 months	No
Temporary Workforce Reduction	690 hours in a 365 Day period	Yes

If an employee is temporarily reducing hours for personal reasons, the only way that the active employee's health coverage can be maintained is to give the employee LWOP status from the classified full-time position and pay the employee on an hourly basis. (Sick and annual leave would not be earned.) The policies and procedures for continuing health benefits coverage would be the same as for personal LWOP.

When an employee transfers within an agency or from one agency to another, the employee must be maintained in the current health benefits membership and plan.

Employees may not change their health benefits membership or plan when they transfer within the same agency or between agencies. There is one exception: when an employee moves out of the health benefits plan's service area, the employee is allowed to select a plan that serves his area. A change in plan must be submitted within 31 days of the move, with coverage effective the first day of the month following receipt of the notification.

Coverage in the new agency will become effective on the same date that it would for a new employee.

Example: An employee terminates employment with Agency A on July 15 and begins work with Agency B on July 16. The employee is covered under Agency A through July 31. Coverage under Agency B will begin August 1. The BES record should be transferred with an effective date of August 1. The receiving agency will need to assure that the health benefits and flexible benefits carry forward as elected at the previous agency.

To assure a smooth transition from active employee coverage to retiree coverage, it is important for the last employing agency to assist retiring employees with enrollment in the retiree group. This is usually the only time for enrollment in the retiree group (see below). It is strongly recommended that an enrollment form is completed at the same time the employee applies for retirement, preferably 90 days before retirement, and **no later than 31 days from the actual date of retirement**. . The 31-day enrollment period also applies to employees retiring from VSDP long term disability—see Section 5.14 for more information. Retiring employees should understand that, with minimal exceptions—see below, this is their only opportunity to enroll in the retiree group

After the last employing agency moves the employee into the retiree group, VRS acts as Benefits Administrator for the majority of State retirees. However, the last employing agency will continue to administer health benefits for retirees with Optional Retirement Plans (ORPs) or Local Retiree benefits.

The only exceptions which allow retirees to enroll after 31 days from retirement are:

- State retirees who properly waive coverage as a retiree to enroll as a dependent on their spouse's active or retiree state health benefits membership may enroll in the retiree group within 31 days of the date that this coverage is lost. To document and preserve eligibility for the retiree group, these retirees should submit the waiver section of the enrollment form within 31 days of their retirement date.

- Certain designated involuntarily terminated State employees with at least 20 years of creditable service who defer retirement may enroll at a later date. (Consult the State's Policies and Procedures Manual for additional information).

Eligibility For The Retiree Group

To be eligible for the State's Retiree Group, the following criteria must be met:

- The individual is a retiring State employee who is eligible for a monthly annuity from the Virginia Retirement System or a periodic benefit from one of the qualified Optional Retirement Plan (ORP) vendors, ***and***
- The individual is receiving (not deferring) the annuity or periodic benefit immediately upon retirement, ***and***
- The last employer before retirement was the state, ***and***
- The individual was eligible for coverage as an active employee in the State Health Benefits Program up until his/her retirement date (not including Extended Coverage), ***and***

- Within 31 days of the individual's retirement date, an enrollment form is submitted to his/her agency Benefits Administrator.

There are limited instances when a Local or State employee is eligible to elect a locality's retirement benefit in lieu of a State retirement benefit but maintain eligibility for State health care benefits.

See Section 5.8 for disability retirement guidelines for those whose disability retirement is approved retroactively.

VRS Retiree

State employees who retire and will receive a monthly benefit from the Virginia Retirement System are identified in the health benefits system as Retirees in agency 005. Group code varies depending on whether they are service or disability retirees.

Optional Retirement Program

These are state employees who retire and receive an immediate periodic benefit from one of the Optional Retirement Plan vendors, such as TIAA-CREF. They are identified in the eligibility system in agency 007, group 008.

Retirement from Military Leave Without Pay

State employees on approved Military Leave Without Pay and who are eligible for and elect to take service retirement (not deferred) from the Virginia Retirement System (or who are eligible for and take a periodic benefit from one of the qualified Optional Retirement Plan vendors) immediately upon termination of Military Leave may enroll in the State Retiree Health Benefits Program within 60 days of their retirement date, regardless of whether they actively return to work at the end of the leave. Retiring employees must have been eligible for coverage under the State Health Benefits Program prior to the start of their leave. Enrollees must be otherwise eligible for the retiree program and adhere to all program provisions after enrollment. Medicare-eligible retirees must select a plan that coordinates with Medicare. If enrollment is not completed within 60 days of the retirement date, there will be no future opportunity to enroll.

Local Retirees

Based on contract or legislative provisions, some retirees are eligible for coverage in the Retiree Health Benefits Program when they elected a locality's retirement benefit in lieu of a State retirement benefit. In a few instances, the retiree will have a VRS retirement benefit but their employment was transferred from a State position to a local entity. They are identified in the eligibility system in agency 007, group 007.

Annuitant Survivors of Retirees

If a retiree or employee dies and had made provisions for VRS survivor benefits and the survivor takes that monthly benefit, the annuitant family member will be eligible for health care benefits in the Retiree Health Benefits Program. Annuitants will be offered coverage whether or not they were enrolled as dependents on the retiree's/employee's health benefits plan prior to death. However, if a retiree had canceled or otherwise lost his/her own eligibility for coverage prior to death, his/her survivors will not be eligible to enroll as new members at the time of death, regardless of their survivor annuity status. Survivors of active employees who had waived their active coverage are also ineligible, regardless of their survivor annuity status. Annuitant surviving spouses may maintain eligibility for continuous coverage during their lifetime, but plan eligibility limitations apply for dependent children. Additional dependents may be added to the Surviving Spouse's coverage with a qualifying mid-year event or at open enrollment (non-Medicare only). However, upon the death of the surviving spouse, other dependents covered through the spouse's eligibility will be terminated and offered Extended Coverage and conversion privileges. Surviving children covered without a parent may maintain coverage based on the active employee dependent eligibility rules. To enroll in or continue coverage, the family member must apply within 60 days of the death of the retiree/employee.

Non-Annuitant Survivors of Retirees

If a retiree or employee with family or dual membership dies, covered family members may remain in the Retiree Health Benefits Group as survivors, even if no VRS annuity has been provided for them. However, non-annuitants who were not covered in the state health benefits plan before the death of the retiree or employee may not be covered as a survivor. Eligible spouses may continue health benefits in the retiree group until they become covered by another health plan, remarry or die. Non-annuitant dependent children may be covered until the age of 21 or up to age 25 if they are full-time students. If the child is incapacitated and incapable of self-support, coverage may be continued after the limiting age if approved by the plan (see section 4.8 for additional information). Children covered under the membership of a surviving spouse will be eligible only for Extended Coverage benefits or conversion privileges in the event of the surviving spouse's death. To continue coverage, eligible family members must apply within 60 days of the death of the retiree/employee.

Public Safety Workers

Certain employees disabled in the line of duty and their dependents, as well as the surviving spouse and any dependents of certain public safety employees killed in the line of duty, may present a claim for benefits to the chief officer, or designee, of the appropriate division or department that last employed the deceased or disabled employee. Claim forms may be obtained from the State Comptroller's office. Approved beneficiaries may be entitled to health insurance coverage as defined by the Line of Duty Act. If those beneficiaries are also eligible for coverage under provisions of the State Retiree Health Benefits Program (e.g., as retirees, LTD participants, survivors), the Department of Human Resource Management will accept premium payments directly from the Department of Accounts.

Last Day Of Coverage In Active Group

The retiring employee may remain in the active group until the end of the month preceding the effective date of service retirement.

Faculty members on 9-, 10-, or 11-month contracts may maintain active coverage until their retirement date. However, if a faculty member retires effective June 1, he/she may not stay in the active group through the summer, regardless of the pay cycle in which he/she participated prior to retirement. Retired employees may not be covered in the active group (except in limited severance situations).

First Day Of Coverage In Retiree Group

Coverage in the retiree group begins on the first day of the first full month of retirement if the retiree enrolls no later than 31 days after his or her retirement date. Even if a retiree waived coverage in the active group, the retiree may elect single coverage at the time of retirement.

See Section 5.8 for additional information about disability retirement effective dates.

Deferred Retirements

Employees who terminate from State service and defer retirement are not eligible to enroll in the State Retiree Health Benefits Program. A deferred retirement is one where the employee terminated State service and did not elect or was ineligible for an immediate retirement annuity. Regardless of retirement eligibility, persons who are covered under the State Health Benefits Program at the time of termination of employment must be offered Extended Coverage.

Membership In The Retiree Group

A retiree may not add dependents at the time of retirement unless there is another consistent qualifying mid-year event which would allow for such an

addition (e.g., spouse ends employment, etc.). However, an active employee who has waived coverage may elect individual coverage at retirement based on that event. Retirees may make consistent plan changes upon enrollment in the retiree group (generally, this means a reduction in plan benefits/elimination of optional benefits). However, if they or any of their dependents are eligible for Medicare, a Medicare-coordinating plan must be selected for all Medicare-eligible participants in the retiree group.

Non-Medicare retirees and non-Medicare dependents will continue to have the same plan options as active employees. Medicare-eligible retiring employees and their Medicare-eligible dependents must change plans to one that coordinates with Medicare.

Many retirees cover both Medicare and non-Medicare participants. If enrolled in Single or Two-Person coverage, each plan member must choose an appropriate Medicare or non-Medicare plan based on his or her Medicare eligibility status. That means that a retiree and a spouse, or a retiree and a covered child may have two different health plans. If that happens, each covered member will receive their own ID card with their own ID number. Family groups of three or more members (for example, a retiree plus two or more dependents with at least one Medicare-eligible member) may remain in the COVA Care non-Medicare Plan (or elect COVA Care if enrolled in an insured plan), but Medicare-eligible family members will be covered by Medicare as the primary payer of their claims.

Changing Plans and Membership After Initial Enrollment in the Retiree Group

Non-Medicare Retirees:

- May cancel coverage at any time (no return to plan);
- May reduce membership prospectively at any time;
- May add or delete dependents or change plan options within 31 days of a consistent qualifying mid-year event, or at Open Enrollment (including Medicare-eligible dependents);

Medicare Retirees:

- May cancel coverage at any time (no return to plan);
- May reduce membership prospectively at any time;
- May add dependents within 31 days of a qualifying mid year event (no Open Enrollment period available);
- May add Dental/Vision coverage to the Advantage 65 or Option II Plans

prospectively at any time, or it may be canceled prospectively at any time. However, once Dental/Vision has been added and canceled one time, participants may not elect Dental/Vision again.

- If enrolled in Option I (Medicare Complementary) or Option II (Medicare Supplemental), may change between those plans prospectively at any time, and they may elect Advantage 65 coverage prospectively at any time. However, if coverage in Option I and II is canceled in favor of Advantage 65, Option I and Option II may not be elected again.

Non-Medicare Retiree Benefits

Plan choices for retirees and dependents who are not eligible for Medicare are identical to those for active employees

The coverage for a non-Medicare retiree or his covered dependents will automatically be transferred to a plan that coordinates with Medicare when the retiree group participant reaches Age 65. However, if the retiree or covered dependent becomes eligible for Medicare prior to age 65, it is the retiree's responsibility to notify VRS, or the appropriate Benefits Administrator, immediately upon his/her own eligibility for Medicare or that of any covered dependents so that a Medicare-coordinating plan can be elected. Failure to do so will result in retraction of primary payments made in error (when Medicare should have been the primary payer).

In dual memberships where one or both participants become eligible for Medicare, separate ID cards/numbers will be generated based on individual plan elections. However, in cases of family membership levels where one or more participants become eligible for Medicare, the family may maintain their family membership under the COVA Care plan, but any Medicare-eligible members will have Medicare as primary coverage. Participants should compare premium costs and benefit levels under COVA Care (family contract) versus split contracts (e.g., one Advantage 65 contract and one dual COVA Care contract, etc., as appropriate) to determine which is most beneficial under individual circumstances.

Medicare-Eligible Retiree Benefits

Once a retiree group member or any of his covered dependents become eligible for Medicare (see above), a Medicare-coordinating plan must be selected if participation in the state program is to continue. With the exception of some cases of End Stage Renal Disease, Medicare will become the primary payer of claims for any participant who is not covered by virtue of current, active employment (e.g., retirees, LTD participants, survivors).

When eligible for Medicare, the retiree or his/her covered dependent should immediately secure Medicare Parts A and B.

In most cases the State Health Benefits Program and Social Security consider

eligibility for Medicare due to age to be the first of the month in which one turns 65. However, someone born the first day of the month will be eligible for Medicare on the first day of the previous month. For example, a retiree born on November 1 will be eligible on October 1; a retiree born on November 2 will be eligible on November 1. Contact the Social Security Administration for additional information about eligibility and enrollment under the standard Medicare plan.

Retiree group participants who are eligible for Medicare but fail to enroll in Parts A and B will have a gap in their benefit coverage since the state plan will not pay benefits that should have been paid by Medicare had proper enrollment taken place. Failure to report Medicare eligibility immediately will result in retraction of primary payments made in error. Medicare eligibility and selection of Medicare-coordinating coverage may be reported to the appropriate Benefits Administrator by submitting an enrollment form or going through EmployeeDirect.

Retiree Fact Sheet #5 is a resource for additional information about ***Medicare and the State Retiree Health Benefits Program***. It is available at the DHRM Web site.

State Plans When Medicare Is Primary

Retirees and dependents enrolled in plans that coordinate with Medicare will be issued separate I.D. cards with their own ID number (except for family memberships as discussed previously). Currently, two Medicare-coordinating choices are available:

- **Advantage 65** is the only Medicare-coordinating plan available to new retiree group members who are eligible for Medicare or existing members who become newly eligible for Medicare.
- **Advantage 65 with Dental/Vision** is also available.

Two additional plans exist for current participants only. Newly Medicare-eligible retiree group participants may not elect these plans:

- **The Medicare Complementary Plan (Option I)**
- **The Medicare Supplemental Plan (Option II)** to which Dental/Vision coverage may be added.

NOTE: Participation in regional plans is not available to Medicare-eligible members.

Important Information About Medicare

As indicated previously, if a Medicare-eligible retiree group participant fails to enroll in Medicare Parts A and B, valuable benefits may be lost. State plans for those who are Medicare-eligible will not pay for services that are ordinarily covered by Medicare.

If not already enrolled in Medicare Parts A and B, those retiree group members eligible for Medicare should contact their local Social Security Office for help or call 1-800-772-1213. In limited circumstances where participants have not worked enough quarters to qualify for Medicare at age 65, they may be allowed to continue non-Medicare coverage until Medicare eligibility occurs. Documentation from the Social Security Administration verifying that they do not qualify for Medicare will be required.

Medicare Part A is hospital insurance and is free to eligible beneficiaries. Generally, new beneficiaries will receive information from the Social Security Administration three months before eligibility. However, if information is not received, contact Social Security immediately by calling 1-800-772-1213.

Medicare Part B is medical insurance and requires payment of a monthly premium which is subject to change each January. Those who keep working beyond Age 65 may request to postpone enrollment in Part B until retirement; however, failure to enroll in Part B at the time of retirement or long term disability from active work may result in a premium surcharge. Part B covers doctor bills, outpatient hospital care, and other medical services not covered by Part A.

The deadlines for applying for Part B are as follows:

Upon approaching the age of 65, eligible individuals initially have seven months to sign up for medical insurance (Medicare Part B). This seven-month Initial Enrollment Period begins three months before the 65th birthday, includes the month in which the individual turns age 65 and ends three months after that birthday month. If an individual enrolls during the first three months of this enrollment period, the individual's medical insurance protection will start with the month the individual is eligible. **If the individual enrolls during the last four months, the individual's Part B coverage will start one to three months after the individual enrolls.** If the individual does not enroll during this Initial Enrollment Period the individual will be allowed to apply during the January through March General Enrollment Period each year, but a 10% premium penalty is incurred for each 12-month period in which the individual was eligible, needed Part B coverage, but did not apply, and coverage will not begin until July of the year in which the General Enrollment Period is utilized.

Under certain circumstances, the individual can delay Part B enrollment without

penalty. The individual can delay Part B enrollment if he/she is either:

- Age 65 or older and has group health insurance based on the individual's own or spouse's current active employment, or

- Disabled and has group health insurance based on his/her family member's current active employment.

If the individual delays Part B enrollment for one of the reasons above, the individual can enroll in Part B anytime during a Special Enrollment Period. This means:

- The individual may enroll in Part B at any time while covered under the group health plan based on current active employment; or,

- The individual can enroll in Part B during the 8-month enrollment period that begins the month employment ends or the month the individual is no longer covered under the group health plan, whichever comes first.

  If the individual enrolls in Part B while covered by a group health plan due to current employment or during the first full month when not covered by that plan, the individual has the option for coverage to begin on the first day of the month in which he/she enrolls. Enrollment after that time may result in a one to three-month delay.

NOTE: Individuals may not exercise their Special Enrollment rights prior to the expiration of their Initial Enrollment Period. This means that if a Medicare-eligible employee retires during the last four months of his Initial Enrollment Period, having declined Part B coverage during the first three months of the Initial Enrollment Period, his Medicare Part B coverage will not begin on the first day of the month in which he enrolls. Instead, there will be a one to three-month waiting period before Medicare Part B coverage begins. Medicare-eligible employees should be careful to coordinate their Medicare Part B enrollment with the beginning of their retiree coverage to avoid any potential gaps.

Effective January 1, 2006, Medicare Part D will become available to Medicare beneficiaries as a result of the Medicare Prescription Drug and Modernization Act of 2003. This provides a prescription drug benefit for Medicare beneficiaries. The State Retiree Health Benefits Program plan benefits will be adjusted to reflect this coverage, but details are unavailable at the time of this HIM update.

Paying Premiums

The retiree pays the full monthly premium for the health care plan—no agency contribution.

- **VRS Retirees:** The health care premium is deducted from the VRS retirement benefit. If the retirement benefit is less than the monthly health benefits premium, the retiree will be billed directly for coverage by the carrier. Effective in January 2005, participants who are billed directly by Anthem Blue Cross and Blue Shield may enroll in automatic bank draft to have their premiums automatically deducted from their bank account.

- **ORP/Local Retirees (or LTD Participants):** Retiree group participants who do not receive a VRS annuity will be billed directly for monthly premiums. Effective January 1, 2005, direct-billed Anthem plan participants may enroll in automatic bank draft to have their premiums automatically deducted from their bank account.

Claim payments will be put on hold for new retiree group members in direct bill status until their initial premium payment is made. After the initial premium payment, claims will be put on hold on the first of any month for which premium payment has not been received. Upon receipt of the premium, claims will be processed. However, if the premium payment remains unpaid for 31 days, coverage will be terminated.

Health Insurance Credit

Retirees with 15 years or more of creditable Virginia Retirement System service are eligible for a Health Insurance Credit (HIC) to assist with the cost of health insurance premiums. Disability retirees and VSDP LTD participants receive the maximum health credit amount regardless of years of service. The HIC is set by the General Assembly and provides a dollar amount for each year of service, up to a maximum of 30 years. The HIC is applicable to the cost of the retiree's portion of health care coverage only and terminates upon the retiree's death.

The health insurance credit is also available to retirees who are enrolled in a plan which is not offered through the State, including Medicare Part B. The reimbursement amount will be the cost of the retiree's health insurance premium (or portion of a premium) or the amount of the HIC, whichever is less. The VRS administers this program and can provide additional information on the health insurance credit and its use with alternate plans.

Service Retirement: Counseling Retiring Employees and Processing Retirement Benefits

The retiree must complete an Enrollment Form or enroll through EmployeeDirect within 31 days of his/her retirement date in order to participate in the State Retiree Health Benefits Program. If an enrollment form is used, the pre-retirement agency Benefits Administrator must complete the agency section of the form, retain a copy for file and submit the original form to VRS (ideally, 90 days before retirement) for all VRS retirees. ORP or local retiree documentation will remain with the pre-retirement agency's Benefits Administrator. The retiree's enrollment form election is to be entered into the Benefits Eligibility System (BES) by the agency. Also the agency must certify the years of service for the purpose of the Health Insurance Credit.

Some additional responsibilities of the Benefits Administrators at the time of an employee's retirement are:

- If the employee had coverage under the active plan at the time of retirement, provide an Extended Coverage Election Notice. This is a requirement of the Public Health Service Act, and failure to provide an election opportunity to any terminating employee, including those who are retiring, results in potential liability to the program. Most retiring employees will elect coverage under the retiree plan instead of Extended Coverage since the duration and cost of Extended Coverage, governed by the Public Health Service Act, is generally less favorable for the retiree. However, to comply with the law, an offer must be made. See Section 2.7 for more information about Extended Coverage.
- Provide the employee with materials to assist in making a coverage decision, including Retiree Fact Sheets, member handbooks, premium rate sheets, and enrollment materials. Be sure to stress that enrollment in the retiree group is a one-time opportunity. Failure to enroll within 31 days of the retirement date generally results in loss of eligibility for the program (see Section 5.7 for more detail).
- Be sure that the retiree and his covered dependents have selected a plan based on their Medicare eligibility. For retirees or their dependents who will turn age 65 within 60 days after retirement, it is recommended that two Enrollment Forms be completed at the time of retirement, one for non-Medicare coverage and one to enroll in a plan that coordinates with Medicare. The second form should reflect the effective date of Medicare coverage. Completing the Medicare form in advance will save time and avoid confusion at the time of Medicare eligibility.
- If the retiring employee does not wish to enroll in retiree coverage, encourage him/her to document his/her declination on an enrollment form. Advise the employee that he/she will not be eligible to enroll beyond 31 days from the retirement date. While a documented declination is preferable, enrollment will not be processed after the 31-day enrollment period, regardless of whether a declination was submitted.
- Advise the employee of the amount of the first premium and how it is to be paid. (See section 5.7 for additional information on methods of premium payment.) VRS deducts premiums in arrears (the month after the coverage

month), but direct billing occurs in advance of the coverage month.

- Advise retirees who have questions regarding the Health Insurance Credit Program to contact the Virginia Retirement System.
- Advise new retirees that they should contact the appropriate retiree Benefits Administrator if they need information after retirement regarding eligibility for the program, enrollment and changes. For VRS retirees, VRS acts as their Benefits Administrator. ORP and Local Retirees should continue to use their pre-retirement agency's Benefits Administrator. Claim or direct billing questions should be addressed to the claims administrator—Anthem or Kaiser, as appropriate. The Benefits Administrator is responsible for keying the initial retiree health benefits record into the appropriate agency/group in BES (see Section 5.7). The ***BES Instructions Guide***, available on the DHRM Web site, is a good reference for keying issues.

Disability Retirement: Counseling Retiring Employees and Processing Retirement Benefits

Note: Employees enrolled in VSDP are not eligible for disability retirement.

Employees who are awaiting approval of a disability retirement but have depleted their sick leave balances may maintain state coverage as follows:

- If approved for a sick leave without pay, coverage may be maintained, with the employer contribution, for 12 months.
- Any period of sick leave without pay will run concurrently with eligibility for Extended Coverage, which should be offered at the start of the leave based on the reduction of hours. If approval of the disability retirement is still unresolved at the end of the 12-month leave period, the employee may exercise the remaining six months of Extended Coverage (12 months on leave plus an additional six months = the 18-month Extended Coverage period—see Section 2.7 for more information about Extended Coverage). Failure of the employee to pay the appropriate premium contribution will result in termination of coverage.

  If a disability retirement is granted retroactively, but prior to the end of coverage in the active group (with the employer contribution), the employee should be removed from the active group at the end of the month in which the VRS notification letter is dated. Health benefits in the retiree group will be effective the first of the month following the date of the VRS notification letter if timely enrollment is completed. (Do not remove the employee retroactive to the retirement date.) In these cases, when the PMIS transaction to move the employee to retirement is completed, an opportunity will be provided to designate a BES termination date. If the date is incorrect (due to a pre-determined leave-end date), it can be changed to reflect the end of the month after the notification letter date.

Agencies should retain a copy of the Enrollment Form for their records. In the case of all VRS retirees, including disability retirees, the original form should be forwarded to VRS.

When Group Coverage Ends Before Disability Retirement Is Approved

If the employee exhausts all of his/her non-retiree state health benefits eligibility (e.g., LWOP, Extended Coverage) prior to disability retirement approval, he/she must be terminated in BES. In these cases, the following options may apply:

If the employee meets the requirements for VRS service retirement, the employee may take a service retirement while waiting for disability approval and may enroll per the eligibility guidelines for the State Retiree Health Benefits Program. Should the disability application be approved, an adjustment in retirement benefits and the Health Insurance Credit is made retroactively. If the disability application is denied, the retiree has ensured that the one-time opportunity to enroll in the retiree group has not been lost.

The employee may convert to non-group coverage. Employees have 31 days from the date coverage ends to apply for conversion to an individual policy (including the end of Extended Coverage). Employees should consult their Member Handbook for additional information.

In all cases when active coverage ends (not including Extended Coverage) it is the responsibility of the Benefits Administrator to provide a HIPAA Certificate of Creditable Coverage to affected individuals.

If coverage is not maintained during the period while awaiting approval of the disability retirement, enrollment in the State Retiree Health Benefits Program will be allowed at the time that the disability retirement is approved if the enrollment occurs within 31 days of the date of the notification letter. The effective date of coverage may be either:

- The effective date of retirement, but the retroactive coverage period may not exceed 12 months for the self-funded plans or two months for any insured plan; or,
- The first day of the month following the month in which the disability notice is dated.

In any case, the retiree is responsible for premium payments for all periods of coverage, including any retroactive coverage.

If denial of disability retirement results in a deferred service retirement, eligibility for retiree health benefits is lost.

Recall of VRS Disability Retirement

The VRS may request an annual evaluation to determine if the retiree is still disabled. All rights to further disability benefits will cease and be recalled if

VRS concludes the retiree does not meet the criteria to continue receiving the disability benefit. If a retiree loses eligibility for VRS disability retirement benefits due to recall, eligibility for retiree coverage also ends. Under those circumstances, some options may include:

- In limited cases, Extended Coverage may be available. Contact DHRM for assistance.

- The individual may convert to non-group coverage within 31 days of losing eligibility in the retiree group. The plan's member handbook will provide additional information on conversion privileges.

Individuals who appeal VRS' decision cannot remain in the retiree group while the appeal is pending. However, if VRS approves the individual's appeal and disability retirement is reinstated, retirees who participated prior to the recall will be eligible to re-enroll in the retiree group. VRS Benefits Administrators will coordinate the individual's re-enrollment. The individual will need to complete a new Enrollment Form.

For employees who have a work-related injury or illness and are enrolled in the Virginia Sickness and Disability Program (VSDP) see Section 5.14.

For employees not enrolled in VSDP, health benefits continue while the employee is receiving full salary. The usual State contribution applies and the same indicator codes are used.

Workers' Compensation, not the health benefits plan, is responsible to cover services which are related to the Workers' Compensation approved condition. When sick and annual leave are depleted and Workers' Compensation benefits continue, the Workers' Compensation benefits are no longer supplemented to achieve full salary. At the point when the employee is given LWOP status, the usual restrictions on benefits for people on LWOP will apply. That is, the employee may keep health coverage for up to 12 months while on a LWOP if there is doctor's certification of disability. The State's contribution continues for 12 months. The indicator codes must be changed to a LWOP code.

If a position must be filled, it is possible to put the employee on a conditional LWOP. Such a leave does not guarantee that a position will be kept open for the employee. It allows the agency to fill the position while retaining benefits for the employee.

For an employee who terminates or retires, see the appropriate sections of this manual.

Workers' Compensation Program Guidelines on Claims

The Workers' Compensation Program will issue payments for all related medical treatment and prescriptions on a denied injury by accident claim up through the date of the claim's denial if the employee and his agency meet the following conditions:

1. The employee must have health insurance with the Commonwealth of Virginia.

2. The employee must immediately notify the agency of his injury and cooperate in a timely manner with all requests for information. (Timely manner means responding to letters within one week of receipt, and responding to phone messages within two days at WCP's discretion.) Except in cases of emergency room visits for treatment, no medical treatment received prior to the employee's notification of the injury to the employer or prior to the employee's selection of a panel doctor will be considered.

3. Upon the employee's notification of the injury to the agency, the agency must offer the employee a panel of physicians and the employee must select a

physician from the panel for treatment. The agency shall provide a copy of the signed panel selection form with the Employer's Accident Report.

4. The agency must submit the Employer's Accident Report to the Workers' Compensation Program within 10 days of the injury as required by Executive Order 52 (99).

5. Other than cases of emergency room visits, all treatment considered for payment must originate with the selected panel physician or be from a referral by the panel physician.

6. If the employee is insured by the COVA Care plan administered by Anthem, the employee must sign and return to the benefit coordinator the Assignment of Benefits form within 30 days.

Special Notes to the Workers' Compensation Program Guidelines on Denied Claims

The Workers' Compensation Program will not pay for any related medical treatment or prescriptions on denied Occupational Disease claims or Ordinary Disease of Life claims as defined by § 65.2-400 through 407.

In cases of denied injury by accident claims, inpatient hospital stays and surgical procedures that are normally covered under the employee's health insurance will not be covered under these Workers' Compensation Program guidelines. In the event that one of these situations arises, the employee may wish to consider concurrent certification through his health insurance program or personal health care provider.

All requests to deny reimbursement as a result of failure to comply with any of the conditions of this policy require written approval of the Director of the Office of Workers' Compensation in the Department of Human Resource Management.

Dropping The Employee From The State Group

If an employee dies while in service, coverage for the enrolled family members, including the employer contribution, may extend to the end of the month following the month in which the death occurs. (Membership level may not be changed during that additional month's coverage.) If an eligible survivor elects to enroll in the retiree group coverage, that coverage will begin on the first day of the month after active coverage ends.

Coverage For Survivors

Eligible annuitant or non-annuitant survivors may elect to continue coverage in the state plan if they enroll within 60 days of the date of the employee's death. A letter should be sent to eligible survivors explaining their options. Sample letters are provided at the end of this section.

Annuitant Survivors may elect coverage in the retiree group, regardless of whether they had coverage prior to the employee's death if:

- the dependent will receive survivor annuity benefits under the VRS death-in-service provision; or
- the employee had submitted a disability retirement application electing a survivor option before his/her death and the employee died prior to achieving the retirement date; or
- the death was job related.

However, if the employee had waived active coverage, the survivors are ineligible for coverage, regardless of their survivor annuity status.

After enrollment, an annuitant surviving spouse may maintain eligibility for continuous coverage during his/her lifetime, but plan eligibility limitations apply for dependent children. Upon the death of the surviving spouse, all other dependents covered through the spouse's eligibility will be terminated and offered Extended Coverage and conversion privileges. Annuitant surviving children covered without a parent may maintain coverage based on the active employee dependent eligibility rules.

Non-Annuitant Survivors of deceased employees (survivors who are not eligible for or do not elect to receive an annuity from VRS), who are covered by the State Health Benefits Program at the time of the employee's death (including covered survivors of employees in approved Optional Retirement Plans), can continue to be covered under the Program if they enroll within 60 days of the employee's death. Non-annuitant surviving spouses may continue coverage in the program until they become covered under another health plan, remarry or die. Non-annuitant dependent children may be covered until age 21, or to age 25 as full-time students. Surviving children covered under the membership of a surviving spouse will be eligible only for Extended Coverage benefits or conversion privileges in the event of the surviving spouse's death.

Survivors of State Employees on Approved Military Leave Without may enroll in the State Retiree Health Benefits Program within 60 days of the date of the employee's death if they are immediately eligible for and elect to receive survivor annuity benefits from the Virginia Retirement System. The deceased employee must have been eligible for coverage under the State Health Benefits Program prior to the start of the leave. Medicare-eligible enrollees must select a plan that coordinates with Medicare.

Survivors who have continued enrollment in the state program through Extended Coverage up to the date of the employee's death may enroll in the retiree program within 60 days of the employee's death, regardless of eligibility for a survivor annuity. These enrollees may maintain the same plan option or make a consistent reduction in their plan option (e.g., remove optional coverage options), except that Medicare-eligible survivors must select a plan that coordinates with Medicare. Membership level may be reduced but not increased at the time of enrollment in the retiree group.

If enrollment is not completed within 60 days of the employee's death, there will be no future opportunity to enroll. After enrollment in the program, all other program provisions related to either annuitant or non-annuitant survivors will apply as appropriate.

Plan/Membership Changes After Enrollment-- Participating survivors will be allowed to make certain membership or plan changes based on consistent qualifying midyear events or at Open Enrollment (non-Medicare participants only).

Medicare Eligibility-- Participating survivors who are eligible for Medicare at the time of initial enrollment must select a plan that coordinates with Medicare, and retiree program policies for Medicare-eligible retirees will apply. Survivors who become eligible for Medicare prior to age 65 must report that eligibility to their Benefits Administrator immediately. Failure to do so may result in a coverage deficit since the state's Medicare supplement plan will not pay claims that should have been paid by Medicare had proper enrollment occurred.

Premium Payments-- Survivors who are enrolled in the State Retiree Health Benefits Program and who receive a monthly VRS annuity will have their premium deducted from their annuity. However, if the annuity is not sufficient to pay the full premium amount, or if there is no VRS annuity (e.g., non-annuitant survivors) from which to deduct the premium, it will be billed directly by the carrier. Claim payments will be put on hold for new survivors who have enrolled but who have not made their initial premium payment. After the initial premium payment is made, claims will be put on hold on the first of any month for which premium payment has not been received. Upon receipt of the premium, claims will be processed. However, if the premium remains unpaid for 31 days, coverage will be terminated.

Extended Coverage—Dependents (annuitant or non-annuitant) who are covered at the time of the employee's death must receive an offer of Extended Coverage/COBRA in addition to the offer of survivor coverage. While it is to the benefit of many eligible survivors to elect survivor coverage instead of Extended Coverage (since, in many cases, survivor coverage will be available for more than the 36-month Extended Coverage period and survivor coverage

premiums do not include an administrative fee), failure to offer Extended Coverage may result in liability to the program. See Section 2.7 for additional information about Extended Coverage.

Non-Group Conversion Coverage—Based on the termination of active coverage, if applicable, dependents of a deceased employee will also receive, from the plan administrator, an offer of non-group coverage. A conversion offer will also be received at the expiration of Extended Coverage, if elected. Conversion is also an option if survivor coverage is terminated at any time. The Member Handbook has additional information about conversion privileges.

Resources-- Retiree Fact Sheet #10 is a resource for additional information on Survivor Benefits. It is available at the DHRM Web site.

SAMPLE LETTER TO NON-ANNUITANT SURVIVOR

Dear

Please accept the condolences of the (insert ***Agency Name)*** and Department of Human Resource Management regarding the death of (insert ***Employee's Name)***.

As a survivor who is currently enrolled in the State Health Benefits Program, you and any other covered dependents are eligible to continue coverage under the Retiree Health Benefits Program by completing the enclosed Retiree Enrollment Form and returning it to (insert ***name and address of form recipient)*** within 60 days of the date of your (insert relationship, e.g., husband's/wife's) death. Failure to enroll within this time frame will result in forfeiture of your right to enroll as a survivor in the future. If you elect coverage, you may maintain your current plan or make a consistent plan change (generally, a reduction in optional benefits). However, if you or any other covered dependent is eligible for Medicare at the time of enrollment as a survivor, a plan that coordinates with Medicare must be selected for all Medicare-eligible participants.

Please consult your plan's member handbook for additional information regarding eligibility limitations for surviving dependents. The Department of Human Resource Management's Web site also includes a series of Retiree Fact Sheets that are useful resources regarding retiree health plan issues. The Web site address is www.dhrm.virginia.gov/hbenefits/retiree.html.

As provided by the Public Health Service Act, certain beneficiaries covered at the time of an employee's death must be offered Extended Coverage, and an Election Notice is enclosed for your consideration. While election and duration of survivor coverage, as discussed above, is governed by § 2.2-2819 of the Code of Virginia, which is administered by the Department of Human Resource Management, election and duration of Extended Coverage is governed by the Public Health Service Act. You are encouraged to read your Extended Coverage Election Notice carefully before making your coverage decision. Should you wish to exercise your rights to Extended Coverage instead of survivor benefits, you may do so by completing the enclosed Election and Enrollment Forms and returning them per the enclosed instructions.

If you need additional information, please contact (insert ***name and telephone number of Benefits Administrator)***.

Sincerely,
Benefits Administrator

Enclosures:

- Retiree Health Benefits Program Enrollment Form
- Retiree Monthly Premiums (Medicare and/or non-Medicare as appropriate)
- Extended Coverage Election Notice
- Extended Coverage Enrollment Form
- HIPAA Certificate of Creditable Coverage (for end of active coverage)

SAMPLE LETTER TO ANNUITANT SURVIVOR

Dear:

Please accept the condolences of the (insert ***Agency Name)*** and Department of Human Resource Management (DHRM) regarding the death of (insert ***Employee's Name)***.

As an annuitant survivor of a state employee, you and any other eligible dependents may elect coverage under the Retiree Health Benefits Program by completing the enclosed Retiree Group Enrollment Form. The completed form should be returned to (insert ***name and address of form recipient)*** within 60 days of your (insert relationship, e.g., husband's/wife's) death. Failure to enroll within this time frame will result in forfeiture of your right to enroll as a survivor in the future. If currently enrolled under the active plan, you may maintain your current plan option or make a consistent plan change (generally, a reduction in optional benefits). However, if you or any other covered dependents are eligible for Medicare at the time of enrollment as a survivor, you must select a Medicare-coordinating plan for all Medicare-eligible participants. If you are not currently enrolled, you may obtain information on available plans at the DHRM Web site. The Web site address is www.dhrm.virginia.gov/compandbenefits.html.

Please consult your plan's member handbook for additional information regarding eligibility limitations for surviving dependents. The DHRM Web site also offers a series of Retiree Fact Sheets that are useful resources regarding retiree health plan issues. www.dhrm.virginia.gov/hbenefits/retiree.html.

(Insert this paragraph if the annuitant survivor was covered at the time of the employee's death.) As provided by the Public Health Service Act, certain beneficiaries covered at the time of an employee's death must be offered Extended Coverage, and an Election Notice is enclosed for your consideration. While the Department of Human Resource Management administers election and duration of annuitant survivor coverage, the Public Health Service Act governs Extended Coverage. You are encouraged to read your Extended Coverage Election Notice carefully before making your coverage decision. Should you wish to exercise your rights to Extended Coverage instead of survivor benefits, you may do so by completing the enclosed Election and Enrollment Forms and returning them per the enclosed instructions.

If you need additional information, please contact (insert ***name and telephone number of Benefits Administrator***).

Sincerely,

Benefits Administrator

Enclosures:

Retiree Health Benefits Program Enrollment Form
Monthly Premiums (Medicare and/or non-Medicare Plans as appropriate)
Extended Coverage Election Notice (if applicable)
Extended Coverage Enrollment Form (If applicable)
HIPAA Certificate of Creditable Coverage (if applicable due to end of active coverage)

Coverage continues to the end of the month in which an employee terminates. The following steps will ensure that terminating employees may keep their coverage continuous.

1. Tell the employee that coverage will continue until the end of the month in which he or she terminates as long as full premiums for the month are paid. If the full month's premium is not paid, coverage will terminate on the last day of the month for which premiums are paid in full. (Any partial premium amounts paid will not be refunded and claims for the period will be retracted.)

   Faculty members who complete the academic year will have coverage through the end of the contract period (July 31 or August 31) unless they waive coverage or retire before that date.

   Please see Section 2.7 for information on the administration of Extended Coverage and Section 2.8 for information on HIPAA and Certificates of Coverage.

2. Tell the employee that it is possible to convert to non-group coverage as well. The terminated employee will receive a letter from the plan administrator explaining that they have a right to convert to non-group coverage. The employee will have 30 days after the date of the letter to reply in order for coverage to be continuous. Additionally, covered individuals may have certain rights under HIPAA. Thus, a certificate of coverage must be issued. If an individual chooses Extended Coverage both the conversion to an individual policy and the HIPAA rights will be available when that coverage terminates unless coverage terminates due to nonpayment of premium.

Coverage continues through the end of the month in which the suspension began, provided the suspension was not effective on or before the first workday of the month. If the employee is suspended pending court action or pending an official investigation, the suspension may go beyond one pay period. In these cases, coverage with the state contribution will continue to the end of the month in which the suspension began. If the employee were reinstated in time to work half of the workdays of the following month, there would be no break in coverage.

Handle suspensions beyond that period in the same way as a LWOP with no State contribution even if the employee is using accrued annual leave to receive pay. The employee may remain in the group by paying monthly premiums as scheduled. Group coverage may continue until a court decision is issued or the official investigation is completed, up to a period of 12 months.

If the employee is reinstated with back benefits, the agency must refund the employee for the amount of the State contribution during the period the employee paid the full premiums. The membership should be reinstated retroactive to the date the employee was removed from the group up to the plan's limitation on retroactivity. If the contractual limitation on retroactivity does not satisfy the period of reinstatement prescribed in the reinstatement order, the agency may assume liability for outstanding claims.

Procedures

Employees who are terminated and file a grievance must be treated as terminated employees. They must be offered Extended Coverage and given a HIPAA certificate. Retroactive Employee membership will be available up to a maximum period of 60 days if the employee has been covered by a regional plan, and up to a maximum of 12 months if membership is through COVA Care. Appropriate premium payments must be made to cover the period.

For employees who are reinstated with back pay, take the following steps.

Reinstating Employees Who Did Not Maintain Coverage

Reinstate the previous membership effective from the date coverage in the agency group terminated. A new Enrollment Form must be completed. The State pays its share of the cost of coverage and the employee must pay his share.

Reinstating Employees Who Maintain Coverage

1. Reinstate the previous membership effective from the date coverage in the agency group terminated up to the plan's limitations. You may "re-activate" the previous Enrollment Form for this purpose. The State pays its share of the cost and the employee must pay his share.

2. Contact the Health Benefits Program at DHRM in writing to arrange for a retroactive cancellation of Extended Coverage or non-group coverage. If there were any claims paid during the period of other coverage in the same State health benefits plan, there will also be an adjustment in claims paid, when necessary.

General - Employees on long term disability (LTD) may enroll in the State Retiree Health Benefits Program if they do so within 31 days of their loss of active coverage (the end of the month in which short-term disability ends). This applies not only to VSDP LTD participants, but state employees covered and determined to be disabled under university-sponsored disability programs. LTD participants pay the full cost of the health insurance premium (no agency contribution) beginning the first day of the first full month of LTD benefits. However, VSDP/LTD participants are eligible for the maximum health insurance credit up to the cost of the employee's premium for single coverage, regardless of the number of years of VRS service credit accrued. (Contact VRS for more information about the health insurance credit.)

Participants starting LTD have the following options:

- They may maintain their current (active) membership level.
- They may enroll in single coverage from active waive status.
- They may waive coverage or reduce membership, but they may not add dependents. They may make consistent plan changes (generally, a reduction in optional benefits), and those who are eligible for Medicare must select a Medicare-coordinating plan.
- They may waive coverage if eligible to participate as a dependent in the active state plan and then (re)enroll in the retiree program within 31 days of losing that coverage.

After initial enrollment (or waiver), LTD participants may make plan/membership changes under the following circumstances:

- They may enroll (if properly waived), increase, reduce, or waive membership, or they may make a plan change (e.g., when moving in or out of a plan's service area), any of which are due to a consistent qualifying mid-year event as long as it is reported within 31 days of the event.
- They may enroll (if properly waived), increase, reduce, or waive membership, or they may change plans at Open Enrollment (non-Medicare participants only).
- LTD participants may cancel coverage for dependents prospectively at any time. However, dependents may be re-enrolled only during Open Enrollment (non-Medicare only) or due to a qualifying mid-year event as noted above. An LTD participant may also cancel his/her own coverage prospectively at any time; however, an LTD participant who cancels his/her own coverage outside of Open Enrollment and without a consistent qualifying mid-year event will lose his/her right to return to the program under any circumstances for the duration of long term disability.

Premium Payments – LTD participants are responsible for the full cost of their monthly premium (no agency contribution), but they are eligible for the health insurance credit which is administered by VRS and reduces the net cost of their coverage. Claim payments will be put on hold for LTD participants who have enrolled but who have not made their initial premium payment. After the initial premium payment is made, claims will be put on hold on the first of any month for which premium payment has not been received. Upon receipt of the premium, claims will be processed. However, if the premium payment remains unpaid for 31 days, coverage will be terminated. LTD participants whose coverage is terminated due to non-payment of premiums will lose their right to return to the program for the duration of long term disability.

Medicare Eligibility - If an LTD participant becomes Medicare eligible, he/she must select a plan that coordinates with Medicare, and retiree program policies for Medicare eligible retirees generally apply. Likewise, Medicare-eligible dependents of LTD participants must also enroll in a Medicare-coordinating plan.

It is the responsibility of the LTD participant to report Medicare eligibility of any covered family member who becomes eligible for Medicare prior to age 65. Failure to do so may result in a coverage deficit since the state's Medicare supplement plan will not pay claims that should have been paid by Medicare had proper enrollment occurred.

If either an LTD participant or any of his/her covered dependents are eligible for Medicare but enrolled in Family membership, the family group may maintain their Family membership under the COVA Care plan, but Medicare eligible members will have Medicare as primary coverage. Participants should compare premium costs and benefit levels under COVA Care (family contract) versus split contracts (e.g., one Advantage 65 contract and one dual COVA Care contract, etc., as appropriate) to determine which is most beneficial under individual circumstances.

Positive Enrollment -Employees on LTD must submit a completed Enrollment Form or enroll through EmployeeDirect within 31 days of their loss of active coverage. Failure to take a positive enrollment action at the start of LTD, including those who had waived their active coverage, will be terminated from the program and will have no enrollment rights for the duration of LTD. If they do not wish to continue coverage, but they wish to maintain their right to enroll in the future, a properly executed form must be submitted to waive their status in the BES system within 31 days of their loss of active coverage.

LTD-Working - Employees on Short Term Disability who go to LTD-Working status (and have not been on LTD) will continue to pay the employee cost of the premium, and the agency will continue to pay the agency cost of the premium during the LTD-working period. Once an employee goes on LTD, however, he/she may not return to LTD-working status.

Retirement from LTD - LTD participants who retire with an immediate VRS annuity (not deferred), maintain LTD benefits without break, and are otherwise eligible for retiree coverage may enroll within 31 days of their retirement date, regardless of their participation or cancellation during the LTD period.

Extended Coverage and LTD - Extended Coverage, if applicable, runs concurrently with the period of LTD. The Extended Coverage qualifying event is the end of active coverage (reduction of hours resulting in the loss of employer contribution to coverage). Extended Coverage must be offered at the start of LTD if the employee had coverage at the end of month in which Short-Term Disability (the qualifying event) ends. Failure to do so may result in liability to the program. If an LTD participant terminates employment (e.g., resigns, takes a refund of his/her VRS contributions, ceases to be disabled under the provisions of the VSDP) after the start of LTD coverage but prior to exhaustion of the full Extended Coverage period, any remaining months of Extended Coverage may be used. However, if no election was made at the start of LTD and the Extended Coverage election period has expired, no additional coverage should be offered. Please see Section 2.7 for more information about Extended Coverage.

Resources – Retiree Fact Sheet #11 is a resource for additional information on VSDP/LTD and the State Retiree Health Benefits Program. It is available at the DHRM Web site.

When An Employee Returns To Work

If the employee has been on LTD less than 30 days, they must return to the options they had selected prior to going on LTD.

If an employee has been on LTD for 30 days or more, a positive enrollment action is required within 31 days of the rehire date.

- If the employee has maintained coverage, but reduced membership, the employee may increase membership upon returning to work.
- If the employee has waived coverage or coverage has been terminated, he/she has the same rights as a new employee.
- If a timely election is not made upon returning to work, the employee may enroll at Open Enrollment or upon the occurrence of a consistent qualifying midyear event.

The agency contribution will begin as follows:

- If coverage was maintained during LTD and enrollment for active employee coverage is completed within 31 days of the rehire, the agency contribution will begin the first of the month after the end of LTD.
- If coverage was waived or terminated during LTD, the agency contribution will begin prospectively from the date that the enrollment form is received (as long as it is received within 31 days of the return to work), but no earlier than the first of the month after the end of LTD.

Health insurance is available to regular, full-time or part-time salaried faculty members. A regular faculty member is a person under contract to teach at least one full academic year. A full-time member carries a teaching or research assignment which, according to the uniform rules of the school, is determined to be full-time. A salaried member receives a State paycheck and is not an hourly employee.

Health insurance for regular, full-time or part-time salaried faculty members may continue for a period of twelve (12) months. The period of coverage normally will begin August 1 or September 1 in accord with the contract for the academic year. Faculty members whose contract for the academic year has a mid-month effective date will have coverage effective the first of the following month if an Enrollment Form is received prior to that time. Contract year coverage ends twelve (12) months later, normally on July 31 or August 31. In this instance coverage through the summer months is not contingent upon signing a contract for the following academic year.

When a faculty member is hired for one semester only, health benefits are not available. If, however, the college or university clearly intends to extend the faculty member's employment with a new contract in the fall, coverage for the spring semester will be available. The intent to enter into a contract with the faculty member in the fall must be documented.

If a faculty member is granted leave without pay (LWOP), the same health benefits and LWOP rules which apply to classified employees shall apply to faculty members for the purpose of determining eligibility for active employee coverage, Extended Coverage, and payment of premiums.

If faculty members on a 9-, 10-, or 11-month appointment are on leave and keep coverage effective through the last month of the academic year, coverage may continue through July 31 or August 31, as appropriate, with the State contribution available for the summer months. The summer months are not considered part of the leave unless the leave continues beyond the beginning of the academic year. If the summer months extend the leave beyond the time that coverage may be continued while on leave, the rules regarding coverage while on LWOP pertain.

Example: A faculty member whose coverage started September 1 takes a personal leave beginning February 1. The academic year ends May 10. The person on leave would pay the full cost of coverage for February, March, April, and May. The State contribution would be available June, July, and August. Throughout the summer months, the person would be considered to have been on a personal leave for 4 months (February through May). If school begins August 20 and the faculty member is still on a personal leave, the summer months are then counted as part of the leave time. In other words, the person has been on a personal leave for seven months at the end of August. If this is the case, coverage

may not extend beyond July 31, because only six months of coverage are allowed for personal leave without pay.

If a faculty member waives coverage while on a LWOP, he or she may not elect to re-enroll in the Group during the period of the leave. If the faculty member who waives coverage is on LWOP through the end of the academic year, coverage is not available for the summer months. Application may be made for coverage which coincides with the new contract year.

Collecting Premiums For Employees On A 9-, 10-, Or 11-Month Appointment

Premiums for the summer months must be collected by payroll deduction or by personal check if an employee with premium liability does not receive a paycheck during the summer months.

If premiums for the summer months are collected by personal checks, the checks should be submitted by the first day of the month of coverage.

If Premiums Are Not Paid

If an employee who is eligible for the State contribution during the summer months fails to make payment for his share of the premium, coverage must be dropped. Coverage will be dropped on the last day of the month for which a premium has been paid. Notify the employee in writing that coverage has been terminated. Terminate coverage on the BES record.

6.2 EMPLOYEES' DEPENDENTS WHO DO NOT HAVE A SOCIAL SECURITY NUMBER

Dependent Social Security Numbers

Generally, dependents are identified in the BES system by their Social Security Numbers. Newborns may be temporarily added to the BES system by using 999-99-9999 in place of their pending Social Security Number (system will assign a random "9xx" number). However, after 90 days, the continued use of a "9xx" Social Security Number will freeze the record, preventing any future changes until an actual Social Security Number is provided. Social Security Numbers for newborns are automatically generated based on paperwork submitted by the hospital at birth. In the State of Virginia, this typically takes seven weeks to process. In no case should a newborn be given a permanent fictitious/assigned ID number in the "8xx" series.

Some alien/non-citizen dependents may not be able to provide a Social Security Number, but instead may present an Individual Taxpayer Identification Number (ITIN). This is acceptable since legally admitted aliens who do not have authorization to work in the United States do not have Social Security Numbers. If a dependent is able to provide documentation of his TIN, he may be added to the BES system using an 888-88-8888 in the place of a Social Security Number (the BES system will assign a random "8xx" number). Use of the "8xx" series will allow for future changes to the record. The Department of Human Resource Management must enter all "8xx" series identification numbers.

Coordination of Benefits (COB) is a method which avoids duplicate payments for the same service. All State employee health benefits plans provide for coordination of benefits. If a person covered by the State plan has additional health care coverage, benefits will be coordinated with the other plan if that plan involves employer contributions or payroll deductions and if the other plan is:

1. a group plan;

2. a labor-management trusted plan, union welfare plan, employer organization plan, or employee benefit organization plan; or

3. a governmental program or coverage required or provided by law.

COB does not apply when someone has an individual accident or sickness policy paid for by the insured or when a State employee funds an individual or franchise sickness or accident insurance policy through payroll deduction. For instance, if an employee has a cancer policy paid 100% by the employee for which payroll deductions are taken, there is no COB.

With COB, one of the programs is responsible for "primary coverage" and the other for "secondary coverage." Full benefits are paid by the primary coverage program before benefits of the other programs are calculated. Secondary coverage programs provide benefits only for covered services which are not payable by the primary coverage. When the State plan pays secondary, the payment will be calculated such that the combined primary and secondary coverage will not exceed what the State would have paid if it were the primary payor.

One of the most common situations is where the State employee and his spouse are enrolled in Family membership through different employers. In these cases the birthday rule is used to determine which plan pays primary for dependent children. The plan of the spouse who has the earlier birth date in the calendar year will be primary payor in most circumstances.

Under most circumstances, employees and retirees in the State Health Benefits Program do not have to file claims for health care services. For example, with COVA Care, all network providers, and many non-network providers, submit claims directly.

When An Enrollee Receives Health Care Services . . .

- The identification card should be presented.
- The enrollee should request that the provider submit the claim directly to the health benefits plan.

Because network providers and many out-of-network providers routinely file claims and are familiar with claims procedures, having them file the claim will expedite payment for approved covered services.

Claims Filing Steps

There are, however, times when the health care provider does not bill the health benefits plan directly. In these instances the enrollee must file a claim.

Claims procedures will vary from plan to plan, but generally the enrollee must follow these steps if the health care provider does not file the claim.

1. Complete a claim form provided by the health benefits plan. Carefully follow instructions on the form.

2. Attach a copy of a fully itemized bill to the claim form. An itemized bill usually includes:

    - Patient's name
    - Provider's name
    - Date of each service
    - Description and cost of each service
    - Diagnosis of the condition

3. Forward the claim form and itemized bill to the address shown on the form.

If there are questions about completing the form, attachments to the form, or the claim's status, the enrollee should contact the health benefits plan.

Timely filing is important. Employees should consult their plan's member handbook for specific claims filing deadlines. Claims forms are available through the plans.

Administrative Information

The State Health Benefits Programs are administered by the Department of Human Resource Management. The Office of State and Local Health Benefits Programs provides this Manual to support agency Benefits Administrators. Additionally, the Programs' Web site http://www.dhrm.virginia.gov/compandbenefits.html contains a full library of information on the State Health Benefits Programs. When you have questions or need information not found in this Manual or on the Web site, please contact the Office of Health Benefits Programs.

State Health Benefits Programs
Department of Human Resource Management
101 North Fourteenth Street
12th Floor
Richmond, VA 23219

Accounting Information

The Health Care Accounting Unit in the Department of Accounts audits the group bills and can assist the agencies with problems related to payroll deductions, collection of premiums, etc.

Health Care Accounting Unit
Department of Accounts
101 North Fourteenth Street
2nd Floor
Richmond, VA 23219

Statewide Plans

When questions arise about coverage or claims under the State's COVA Care, Medicare Complementary (Option I), or Medicare Supplemental (Option II) plans, Advantage 65, and the Dental/Vision Plan, call or write appropriate administrator

Anthem Blue Cross and Blue Shield - Medical, Vision and Hearing Benefits
Member Services: (804) 355-8506 in Richmond or 1-800-552-2682 outside Richmond
www.anthem.com

Delta Dental Plan of Virginia - Dental Benefits
Member Services: 1-888-335-8296
www.deltadentalva.com

Medco Health Solutions. Inc. - Prescription Drug Program
Member Service: 1-800-355-8279
www.medcohealth.com

ValueOptions, Inc. Behavioral Health and Employee Assistance Program
Member Services: 1-866-725-0602
www.achievesolutions.net/covacare

Regional Plans

Kaiser Permanente HMO Plan *(Northern Virginia Only)*
Kaiser Foundation Health Plan of the Mid-Atlantic States
(301) 468-6000 in the Washington, D.C. area or
toll free **1-800-777-7902** outside Washington, D.C.
Behavioral Health: Toll free **1-866-530-8778**
Employee Assistance Program: Toll free **1-866-517-7042**
http://www.dhrm.virginia.gov/hbenefits/kaiser.html

How Forms Are Processed

Form	*Where to Submit*	*Reason*
Enrollment Form for Active Employees	All plans—agency enters into BES and retains Enrollment Form	Enrollment/changes
Enrollment Form for Retirees	All plans – agency enters into BES and sends a copy to VRS	Enrollment/changes
Enrollment Form for Extended Coverage Employee/Dependents	Agency enters into BES and retains Enrollment Form DHRM Extended Coverage Administrator	Enrollment Changes
Disability Certification	Agency retains	To continue State's contribution due to illness
Materials Order Form	Commonwealth Mailing Systems	Enrollment Forms/ Provider Directory/Member Handbooks, etc. (all participating plans)
Kaiser Materials	Kaiser	Order Provider Directory, PCP Form
Appeal Form	Director of DHRM	Appeal to Director of DHRM once plan appeals exhausted

Additionally, there is a wealth of information available at the Office of Health Benefits' Websites located at http://www.dhrm.virginia.gov/compandbenefits.html with links to the individual carrier Websites.